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**Health education and health promotion : perceptions and practice of nurses in acute care settings.**

Latter, Susan Marianne

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**Health Education and Health Promotion: Perceptions and  
Practice of Nurses in Acute Care Settings.**

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**Thesis submitted for the degree of PhD**

**King's College**

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## **ABSTRACT**

The aim of this study was to examine nurses' perceptions and practice of health education and health promotion in the acute care setting.

Ward sisters (n=132) working on acute wards in nine District Health Authorities were interviewed using a semi-structured schedule. Data were collected on perceptions of health education and health promotion, nurses' role in these activities, and factors influencing nurses' health education and promotion practice on the ward. Data were analyzed using a combination of qualitative and quantitative methods. In the second phase of the study, three wards were selected as case studies of nurses' practice. Data collection methods employed to describe nurses' practice included: non-participant observation, audio-recording of nurse-patient interactions, self-administered questionnaires and reflective field notes. A largely qualitative approach was taken to the analysis of these data.

The findings from the interviews indicated that the ward sisters had limited understandings of the meaning of health education and health promotion and nurses' roles in these activities. Findings from the case study wards as a whole suggested that nurses' health education and promotion practice was generally extremely limited, although there were some differences between wards in the extent of this evolution. A number of factors may help explain these findings. These include: nurses' knowledge and skills in health education and health promotion, the philosophy, organization and management of care adopted, and the extent to which these offer opportunities for empowerment in nursing.

It is suggested that nurses' perceptions and practice can be conceptualized with reference to a continuum of health promoting nursing practice, and that only limited progress has been made towards nurses' full potential. It is argued that if nurses are to develop their health promoting practice, a philosophical shift in nursing is necessary. Together with the acquisition of appropriate knowledge and skills, this may empower nurses to realise their potential.



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## **INTRODUCTION**

In recent decades, health education and health promotion have assumed increasing importance within society generally and in particular within the health care professions. The emphasis on the promotion of health and the prevention of illness has arisen for a number of reasons, including social, economic and demographic trends as well as changes in patterns of morbidity and mortality. A prevailing political ideology which emphasises productivity, competitiveness within market systems and attempts to restrain health service costs have also led to a focus on prevention of disease and education for health. In addition, past decades have witnessed a rise in consumerism in health service provision, beginning with the self help movements of the 1960s and 1970s. Increasingly, people desire more information about their health and its management, including health care and service provision. There has also been a re-emergence of concern over public health issues, such as the cleanliness of water supplies and air pollution, leading to what has been termed “the new public health”.

Against this backdrop, there have been numerous policy recommendations, both national and international, which focus on the need for improvements in health through health education and health promotion. These have ranged from the World Health Organization's global perspective on health promotion enshrined in its proposals for Health For All 2000 (1986a) to the Government's recent policy document, Health of the Nation (1992).

It has been proposed that nurses have the potential to lead this new health promotion movement (World Health Organization 1989) and the nursing profession has been responsive to these changes and trends by placing emphasis on the promotion of health and the prevention of illness as legitimate activities for nurses in addition to the more traditional roles of caring for the sick. The importance of developing the nurse's role in health education and health promotion has been highlighted by recent policy documents issued by nursing's professional and statutory bodies. For example, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting's (1986) proposals for the future of nurse training and education are firmly orientated around the need for nurses to develop their role in health promotion. The Royal College of Nursing (1989) sees the development of activities related to the promotion of health and the prevention of disease as one of the routes to professional excellence. In its Strategy for Nursing (1989), the Department of Health recommends that one of its targets for practice is that:

**“Health education and health promotion should be a recognized part of health care; all practitioners should develop skills in, and use every opportunity for, health promotion” (Department of Health 1989:34).**

Whereas in the past, activities concerned with prevention and the promotion of health were seen as the prerogative of Health Visitors and other primary health care workers, the recent emphasis on the nurse's role in health promotion relates to all nurses, including those working in acute care settings within the hospital. Indeed, it could be argued that the latter form a hitherto neglected group whose potential for engagement in health education and promotion has only recently been recognized. Honan et. al. (1988) point out that these nurses are in a key position to carry out health education due to their continuity of contact with patients. In addition, hospital nurses are an accessible source of health advice during a time which may represent a crisis or period of transition for patients and so force health and illness issues to the fore.

However, despite the plethora of recommendations, there has been little attempt in the nursing literature to clarify the meaning of the concepts “health education” and “health promotion”. In the absence of engagement in dialogue about these issues, it seems that a common understanding of these terms is assumed and there has been a lack of exploration of hospital nurses' role in these activities. Such a presumption stands in direct contrast to the debate that has raged in the health education and health promotion literature concerning the appropriateness of different theoretical perspectives, concepts and models. The previous lack of agreement has been such that Saunders (1988) was prompted to remark that definitions depend on who you ask. Gott and O'Brien (1990) add that meaning given to these concepts is inseparable from the agenda of the defining parties.

In view of this, and in the absence of any directive from nursing's statutory and professional bodies, it would seem important to study both nurses' perceptions and their practice of health education and health promotion in hospital settings. An examination of this issue is important for a number of reasons. Descriptive and evaluative studies exploring this aspect of nurses' role enable judgements to be made about the effectiveness of current practice based on the theoretical evidence available. In addition, studies which elucidate the stance taken by nurses on health education and health promotion enable understanding of the extent to which they are able to communicate effectively with each other, other professionals and people unfamiliar with the discipline. That is, a clear understanding of purpose and methodology by



those involved in its practice is essential if communication is to take place (French and Adams 1986; Cribb and Dines 1993). Furthermore, research into the way in which nurses' health education and health promotion role is currently perceived and practised has important implications for future policy and planning. Ewles (1988) points out that research into working practice is needed as a basis for identifying training and development needs and in order to provide data to use as a springboard for future planning. Rawson and Grigg (1988) also propose that empirical work of this nature is necessary in order to understand the types of practices that new recruits are exposed to. Clearly, these recommendations have relevance for nurses working in acute care settings as they adopt and develop their role in the promotion of health.

However, to date there has been a lack of rigorous empirical investigation of the way in which nurses interpret and enact the concepts of health education and health promotion in acute care settings. The few studies undertaken in this area have not focused exclusively on nurses working in acute hospital settings (e.g. Gott and O'Brien 1990) and/ or have confined themselves to utilizing self report measures only (Davis 1992; McBride 1992; Bradford and Winn 1992).

The purpose of this study is therefore to examine the perceptions that nurses working in acute care settings hold about the concepts of health education and health promotion and their role in these activities. The study also aims to explore the reality of nurses' practice of these activities, with a particular focus on health education, in view of the fact that the majority of nurses' work is orientated around interactions with individuals.

Chapter One traces the origins of health promotion and the history of nurses' involvement in this movement. The recent emerging consensus of meaning over the term "health promotion" is explored, together with a critique of alternative definitions which have been proposed. The range of information encompassed by health education is outlined. Further, two discernible models of health education, based on a review of the literature, are identified: a behaviour change model and a self empowerment model. The implications for nurses adopting either of these models as a basis for practice are outlined and it is suggested that the latter has important advantages over the former in the quest for ethical and effective practice.

In Chapter Two the research to date which has examined nurses' perceptions and practice of health education and health promotion is examined. A review of the literature revealed that the majority of research in this area has focused on nurses' more traditional roles in patient education and structured information giving. These activities

represent only a limited component of nurses' health education and promotion role. A small number of more recent studies have incorporated an expanded focus (e.g. Gott and O'Brien 1990; Davis 1992; McBride 1992; Bradford and Winn 1992) but due to their reliance on either self report measures or samples outside of the hospital setting, they fail to offer an accurate account of the perceptions and practices of nurses working in acute care settings.

Chapter Three details the methods employed in this study to examine this issue. A combination of qualitative and quantitative methods were used to address the central research questions. Semi-structured interviews were analyzed utilizing a process of content analysis in order to decipher the ways in which nurses interpreted the concepts of health education and health promotion and their role in these activities. In phase two of the study, three wards representing case studies were selected as examples of practice. A multi-method approach to data collection was employed and analysis involved a largely qualitative approach to reflect the nature of the data collected.

In Chapters Four and Five the findings from the interview and case study phases respectively are presented. Main themes emerging from the interview data are presented in Chapter Four, together with some quantification of these where appropriate. In Chapter Five, findings concerning nurses' practice and the influences considered to impinge on this from each of the case study wards are described. This is followed by a summary of findings from the three wards in order to highlight differences and similarities.

Chapter Six offers a discussion and explanation of the findings. Findings from the two phases are drawn together and the relationship between nurses' perceptions and practice of health education and health promotion is explored. A number of key issues which appear to be influential in determining nurses' perceptions and their practice are examined in some detail.

Finally, the implications of the study's findings are drawn together and consideration is given to directions for future research into nurses' health education and health promotion practice.

**CHAPTER ONE**  
**AN EXPLORATION OF THE CONCEPTS OF HEALTH EDUCATION**  
**AND HEALTH PROMOTION AS A FRAMEWORK FOR**  
**NURSING PRACTICE**

**Introduction**

The terms health education and health promotion, and their relationship to one another have been interpreted and labelled in a variety of different ways over the past two decades since the latter term first became widely adopted in the 1970s. Simultaneously, the need to clarify meaning has been recognized (World Health Organization 1984a; Taylor 1990; Tones 1990).

This Chapter provides a critical overview of the literature pertaining to the concepts of health education and health promotion and attempts to illuminate dominant ideas and accepted understandings about ideologies, concepts and principles. The account which follows is partly historical. It traces the origins of health education to its 19th century public health roots, and charts shifts in perspectives which have occurred up to the present day. The accepted meaning and principles of the term “health promotion” are examined, together with alternative accounts which have been suggested. The relationship of health education to health promotion is discussed and a selective review of health education models and typologies follows (more detailed reviews can be found elsewhere, for example French 1984). Health education approaches which derive from a medical model perspective are presented and critically discussed with reference to their likely effectiveness. A self empowerment model of health education is identified, examined and proposed as a more favourable alternative on which to base practice. It is suggested that despite the previous confusion and lack of clarity surrounding the meaning of the terms health education and health promotion, some similarities concerning the essential underlying principles of each can be distinguished. These can serve as a guide to planning and implementing health education and health promotion activities and also provide a framework with which to analyze current perceptions and practices of groups of health professionals, including those of nurses.

**The Origins of Health Education and Health Promotion**

Undoubtedly teaching or wisdom about health and its maintenance has characterized civilizations throughout the ages. Vuori (1980), for example, reminds us that instructions about healthy living habits were typical of Greek, Arabic and medieval

medicine. However, the origins of health education as it is conceived and practised today can be traced back to the mid 19th century. The overcrowding and poor sanitation that resulted from the industrial revolution were the precursors of the first attempts at health education which formed a part of the public health movement at that time. Evidence produced in a document in 1842 by the assistant commissioners of the Poor Law Commission under Sir Edwin Chadwick entitled “General Report on the Sanitary Condition of the Labouring Population of Great Britain” and the reports of successive Royal Commissions in 1844 and 1845 were the stimulus for action. This action appears to have taken two forms: education and propaganda on the one hand and legislation on the other. With regard to the former, various statutory and voluntary bodies were involved in disseminating knowledge about cleanliness and living conditions. For example, Sutherland (1979) cites the chief aim of the Metropolitan Health of Towns Association, formed in 1844:

“to diffuse among the people the valuable information elicited by recent enquiries, and the advancement of science, as to the physical and moral evils that result from the present defective sewerage, drainage, supply of water, air and light, and construction of dwelling houses” (Sutherland 1979: 4).

The origins of the nursing profession’s association with health education can be traced to this era. One of the voluntary groups involved in visiting families in their homes and issuing advice on sanitary matters was the Salford Ladies Sanitary Reform Association. These Ladies were the first manifestation of health visitors, and although initially they were voluntary workers with no specific education or qualifications, some decades later a nursing and midwifery qualification was regarded as preferential for this work.

Legislation to protect public health was also a consequence of the Chadwick and Royal Commission reports. A General Board of Health was set up by Parliament in 1848 which was required to encourage the newly created health districts to institute measures against insanitary conditions and was empowered to sanction those that failed to do so. It is interesting to note that two complementary approaches were taken in an attempt to improve the health of the population. That is, measures were taken at both the individual and structural level. The achievement of an appropriate balance between individual and social responsibility for the protection and promotion of health is an issue which continues to be debated at the end of the 20th century.

For the remainder of the century, the mix of diffusion of information to the public and legislative action continued to constitute the public health movement. The former was

primarily carried out by medical officers of health, a range of influential voluntary health care organizations, and the Temperance Movement and largely took the form of propagandist messages. As Sutherland (1979) points out, propagandism and bullying were fair descriptions of some 19th century notions of education. Furthermore, it is at this juncture that, according to Macdonald and Bunton (1992), the medicalization of the public health movement occurred. Following the second Public Health Act of 1872, local medical officers of health were created and:

“Although these doctors initially had a broad remit that included sanitation and housing, increasingly through the last quarter of the nineteenth century and the first quarter of the twentieth, they began to focus in on the bio-medical aspects of illness and disease which would later result in the lifestyle approach to public health” (Macdonald and Bunton 1992: 10).

On the other hand, Sutherland (1979) suggests that during the latter part of the century, the proper education of the public to ensure they were sensitive to the needs of health was neglected at the expense of regulatory, administrative action which “reigned supreme.” From these accounts, it appears that what was happening in terms of health education was a mixture of propaganda associated increasingly with a bio-medical focus and regulatory legislation to protect health, with little attention to sound educational principles.

The involvement of nurses in this public health movement continued, in the guise of the work of the early health visitors. Writing at this time, Florence Nightingale envisaged a role for nurses which encompassed not only caring for the sick, but also the prevention of illness. Nightingale (1893) understood the concept of health nursing to be “to put the constitution of the healthy child or human being in such a state as to have no disease.” However, at this time nurses’ involvement in the prevention of illness was limited to the work of health visitors and was consistent with the moralising, propagandist messages of the time. Kendall (1991) points out that in view of the moralist basis of much of the early visitors’ motivation to take up this work, it seems unlikely that they entered households free from middle class, Christian values and attitudes and she suggests that there is evidence to suggest that they were not always welcome.

In the early part of the 20th century there were opportunities for health education to develop further: during the Boer War, three out of every five volunteers proved unfit, leading to a “crisis of fitness” (Blythe 1986). National enquiries into health and welfare

led to a concern for infant and maternal mortality and concern for child health also led to the establishment of a School Medical Service in 1908. The concern over infant mortality also led to a change in the focus of health visitors' work, away from the community as a whole towards infants (Kendall 1991). Thus, the early pattern of nurses' involvement in health education has persisted until the recent past. That is, these activities have largely been regarded as the specialist territory or province of the health visitor (Macleod Clark 1993) with an emphasis on prevention and health education with infants and young children.

Blythe (op. cit.) charts some of the problems for health education at this time, many of which have been inherited and passed on through succeeding decades to the present. He states that it had not been clearly defined and meant different things to different people and in addition it was gaining a propagandist image which had dangers. Together with the fact that its more biological and physiological image continued to be encouraged by some, this had the effect of continuing to alienate it from educationalists. Blythe states that the encouragement for propaganda over education continued during World War I and in addition, its major concerns (venereal disease, dirt in the home and infantile diarrhoea, and spitting in relation to the prevention of TB) led to its association with dismal and daunting issues. Further, health education had also become socially polarized, addressed to the working poor by those feeling they knew better. Often its messages were both trite and patronizing and a belief that health education could be economically beneficial prevailed. As Blythe (op. cit.) points out, the view that health education is a cheap palliative has bedevilled its cause down the years. The shift from the environmental concerns of the public health movement in the 19th century can be seen to have given way to a focus on the individual. Macdonald and Bunton (1992) state that by the early twentieth century it was individual health that had become a focus of concern. Kendall (1991) also points out that in the years following the introduction of a compulsory midwifery qualification for entry into the health visiting profession in the 1920s, health visiting became much more orientated to infant welfare whilst the social and environmental aspects of these nurses' work declined.

Both Sutherland (op. cit.) and Blythe (op. cit.) propose that during the next few decades, health education advanced little, its propagandist flavour persisted and it comprised largely a business of publicity campaigns, glossy leaflets and posters. This was despite the formation in 1927 of the Central Council for Health Education (CCHE) - a body led by medical officers of health, which was intended to provide leadership and co-ordination for the field. In a separate paper, Blythe (1985) notes that this left health education a preserve of the least prestigious branch of medicine of the time, and

of the public health movement generally. Nevertheless, it may also have served to reinforce the increasing dominance of medicine within health education and to have sown the seeds for the later medically-derived reductionist approaches to health education which continue to be prevalent today. This is suggested by Macdonald and Bunton (1992) who point out that although the CCHE had the dual functions of encouraging education about healthy living and co-ordinating the work of statutory bodies' duties under the Public Health Acts:

“Unfortunately health education confined itself in the main to the first, largely lifestyle function and neglected the second, largely structuralist issue”  
(Macdonald and Bunton 1992: 10).

Also, during the first half of the 20th century, there was little attention paid to how the health publicity and propagandist messages were registering, that is, there was a lack of feedback from target populations or simple research of any kind (Blythe 1986). This suggests that the nature of health education during this era was predominantly a process of one-way information giving from expert or professional to lay members of the public without specific attention to their perceived needs. In addition, Blythe states that a further major disadvantage was that health education's formative opportunities had arisen in advance of epidemiology or social medicine, disciplines needed for informed perspective.

In the early part of this century then, attempts to improve the health of the populace were characterized by the dominance of medicine and a separation from education and its principles. Health education was largely propagandist and was uninformed by either other disciplines or the needs and desires of the public. It is from these historical roots that some approaches to health education (notably the medical or behaviour change approach) have originated.

The latter half of the 20th century has witnessed a number of important changes and influences that have impinged on the nature of health education. During the 1950s the first training for those involved in health education commenced and the first health education officers employed by local health authorities were appointed. Blythe (1986) suggests that during this time, propagandist views were giving way to more education-minded ones. In 1962 the Council for Education and Training of Health Visitors (CETHV) was created and a new syllabus was introduced. Entry requirements made registration as a nurse mandatory, thus linking nursing more closely with the practice of health education and disease prevention. In 1977 the Council's definition of the role

and function of the health visitor made the centrality of the promotion of health clear. It suggested that guiding principles for practice were the search for health needs, the stimulation of the awareness of health needs, the need to influence policies affecting health and the facilitation of health enhancing activities. However, the association between nurses and the promotion of health remained confined to health visitors and there is no evidence to suggest that this extended to nurses working in hospital settings.

These decades saw the growth of the social and behavioural sciences and epidemiology and these also influenced thinking about health education. Specifically, they led to a consideration of broader approaches to health education and a critique of those that were purely medically derived. Simultaneously, there has been a re-emergence of concern with public health issues, or the “new public health” with concerns about structuralist issues, environment and ecology re-entering the health education arena. Nevertheless, there is evidence to suggest that the propagandist focus on lifestyles continues. Blythe, writing in 1986, states:

“Campaigns against smoking and heart disease and to increase the quest for personal fitness have dominated the character of health education in recent years, often resorting to the kinds of gimmicks and stunts typical of the 1920s and 1930s” (Blythe 1986: 115).

Finally, the term health *promotion* has been increasingly used in the past two decades to refer to certain activities or interventions designed to protect, promote or enhance health. The term first appeared in 1974 when the Canadian Minister of National Health and Welfare, Marc Lalonde, published “A New Perspective on the Health of Canadians (Lalonde 1974 cited in Macdonald and Bunton 1992 p9). This has led to subsequent debate and a certain amount of confusion over the meaning of health education on the one hand and health promotion on the other, and the relationship between the two. A more detailed discussion of this issue is presented in a subsequent section of this Chapter.

To summarize, the origins of health education can be traced back to the public health movements of the mid 19th century when interventions were aimed at both structural change and the provision of information to individual members of the population. The latter largely took the form of propagandist leaflets and publicity campaigns, elements of which continue to prevail today as an approach to health education. Nursing’s involvement in health education can be traced to this period through the work of the early health visitors. The view that health promotion in nursing is confined to the work



of community nurses visiting children and families can also be said to originate in this period. The dominance of medicine in health education can also be traced back to the late 19th and early 20th century and here the roots of approaches to health education based on the principles of medicine, or the medical model, can be found. More recent developments in the social and behavioural sciences have led to alternative models and typologies of health education. New public health issues have emerged which have contributed also to a re-focusing on the structural determinants of health and a critique of medically derived models.

### **Towards A Consensus of Meaning Over Health Promotion**

As indicated above, prior to the 1970s the term health education was used to refer to activities in this field until the emergence of the concept of health promotion introduced by the Lalonde Report in 1974. The section that follows briefly reviews the history of the latter term. The more recent consensus over meaning is then outlined, utilizing relevant literature derived from this field. This illustrates the different elements and principles encompassed by the term health promotion. It also serves to highlight the potential for nurses in their role as health promoters and provides a backdrop against which to analyze their perceptions and practice.

### **The Ottawa Charter for Health Promotion**

In tracing the origins of the concept of health promotion, both Beattie (1991) and Macdonald and Bunton (1992) suggest that its creation was due in part to a dissatisfaction with the narrowly defined, medically-derived behaviour change focus that had developed in the field of health education. The Lalonde Report emphasized the idea that critical improvements in health could result from both environmental or structural changes on the one hand and behavioural or lifestyle changes on the other. This was based on the premise that all forms of death and disability could be attributed to four discernible elements: inadequacies in current health care provision; lifestyle or behavioural factors; environmental pollution; and finally bio-physical characteristics (Macdonald and Bunton 1992). The report, and the introduction of the concept of health promotion contained within it, formed the basis for a series of initiatives over the next decade or so, prominent among which were those by the World Health Organization (WHO). These began with the declaration of Alma Ata in 1978 by the World Health Assembly which committed all member states to the principles of Health For All 2000. Central to the Health For All strategy was the recently developed notion of health promotion, enveloping the idea that both structural and lifestyle elements were

important determinants of health. As Macdonald and Bunton (op.cit.) go on to document, WHO (Europe) subsequently launched its formal programme on health promotion using these twin supporting themes or pillars in 1984 (WHO 1984b) and this then gave rise to the first international conference on health promotion in Ottawa, Canada, in November 1986. It can be argued that the conference was something of a landmark in the history of health promotion - it resulted in the production of a Charter for Health Promotion (WHO 1986b) which has subsequently been used as a framework for planning and action, and some consensus about the meaning of health promotion and its relationship to health education has emerged in its wake.

The Charter is one which outlines action to achieve Health For All 2000 and beyond, and in so doing helps to make clear the essential features of health promotion. Health is viewed as inextricably linked to the context of our everyday lives. The Charter states that health promotion aims at making economic, social and behavioural factors conducive to health through advocacy for health. It is also based on the principle of achieving equity in health - that is, reducing differences in health status and ensuring equal opportunities to ensure all people achieve their fullest health potential. The Charter also states that people in all walks of life are involved in health promotion as individuals, families and communities and it emphasises the principle of their participation in strategies designed to promote health. In this sense then, health promotion embodies a number of important values. Commenting on this literature, Cribb and Dines (1993) suggest that it illustrates that health promotion is not just about the improvement of health, but the improvement of health in ways which accord with a set of values (holism, participation, equity) and an ethos of collaboration and co-operation. Developing this line of argument, they suggest that it is useful to conceive of health promotion as encapsulating a set of values which can be used to measure whether any activity is being approached in a health promoting way. Further, they comment that this is more useful than attempting the notoriously difficult task of defining the boundaries of what constitutes and what does not constitute health promotion activities. With reference to nursing, Macleod Clark (1993) has postulated a similar idea, describing characteristic features and values of an approach to an interaction which she describes as “health nursing”, in contrast to “sick nursing” (this is discussed further below).

The Ottawa Charter nevertheless proposes that health promotion action involves a number of different strategies. These are identified as building healthy public policy; creating supportive environments for health; strengthening community action and participation in the direction of health matters; the development of personal skills for

control of health choices and the environment, and the re-orientation of health services towards health promotion.

As well as recommending these five key areas for health promotion action, the Charter also states that a commitment to health promotion involves responding to inequities in health, inter-sectoral action for health, focusing attention on public health issues such as pollution and housing and acknowledging people as the main health resource and “to share power with other sectors, other disciplines and most importantly with the people themselves.” (WHO 1986b: 3).

The Charter’s five key areas can therefore be seen to encompass action at both the structural and individual level in order to promote health. For example, the building of healthy public policy includes legislation, fiscal measures and organizational change whereas the development of personal skills incorporates the provision of information to individuals and enhancing their lifeskills. Similarly, inherent in the many models of health education and health promotion that have been proposed subsequently is the idea that health promotion involves more than individual education or advice-giving but that the latter may make an important contribution to its twin element of structural action for health. This is discussed more fully below.

### Health Promotion as Individual and Structural Processes

As discussed above, the WHO Ottawa Charter (1986b) marks something of a watershed concerning the meaning of health education and health promotion. Despite the fact that numerous definitions and models have been proposed, an analysis of these reveals a degree of consensus, which is often masked by different labels and terminologies. Essentially, the WHO’s assertion that health promotion combines both structural and individual level action is a recurring feature of much of what has been written in the field. This recent agreement is summarized by Macdonald and Bunton (1992), who state that although definitions of health promotion abound:

“ultimately they all accept that both individual (lifestyle) and structural (fiscal/ecological) elements play critical parts in any health promotion strategy”  
Macdonald and Bunton (1992: 7).

Bunton and Macdonald go on to suggest that both individual and structural elements of health promotion have a number of sub-themes. The sub-themes of the structuralist strand are identified as fiscal and legislative measures (such as alcohol taxation policies

and seat belt legislation) and ecological or environmental measures (such as planting of more trees within an urban conurbation). Both the dual level of operation of health promotion and these sub-themes can be identified in the work of a number of important writers in the field. For example, Baric (1985) in discussing the meaning of health promotion, states that it is concerned with the creation of a social, political and economic environment conducive to healthy lifestyles, whereas health education is concerned with raising individual competence and knowledge. He concludes that their main difference is not so much in their aims and objectives, but in the levels on which these are carried out. Tones, Tilford and Robinson (1990) state that health promotion is concerned to build a system conducive to health through the development of policy at local and national levels. They further suggest that these include legal, fiscal, economic and environmental interventions such as taxation on alcohol or the fluoridation of drinking water. In accordance with the WHO, their view is that health promotion is seen to comprise not only policy interventions, but also health education at the level of the individual.

Similarly, although Downie, Fyfe and Tannahill (1991) criticize views of health promotion which characterize it as an umbrella term incorporating health education and “social engineering”, these very ideas are presented in their model. That is, health promotion is considered to consist of measures at both the individual and the structural level. The sub-themes at the structural level in Tannahill’s (1985) model (cited by Downie, Fyfe and Tannahill 1991) can be identified as: legal controls (stated examples include legislation concerning the sale of alcohol and tobacco, and drinking and driving laws); fiscal controls (examples given are taxation on alcohol, tobacco and unleaded petrol) and other policies which include those related to housing, education employment and poverty.

Beattie (1991) outlines a structural map to depict the repertoire of health promotion. The map divides strategies for health promotion into four distinct quadrants which are a result of separation according to two dimensions: the mode of intervention (authoritative or negotiated) and the focus of intervention (individual or collective). The map makes clear that Beattie considers, like other authors, that health promotion can have the individual or a broader dimension as its focus. In the map, health promotion interventions having a collective focus include both legislative action for health and community development for health. In relation to the former, Beattie states that this is the term used to refer to the cluster of interventions which employ the authority of public health expertise to change civic policies to improve health and gives examples as

environmental controls and taxation. Thus, similarities to other descriptions of health promotion are apparent.

Ewles and Simnett (1992) take a somewhat different approach to delineating the meaning and activities associated with health promotion, but nevertheless, similar features recur. They outline a framework for health promotion based on activities which may be carried out in the pursuance of better health. These are broadly divided into the overlapping spheres of illness and disability services and positive health activities, presumably reflecting the aim of each set of activities. An analysis of the activities included however, once again reveals that both health education programmes aimed at lifestyles and voluntary changes in behaviour and broader, structural level interventions transcend the division into illness and disability, and positive health services. Ewles and Simnett's identified activities include health education programmes, which are "planned opportunities for people to learn about health", and economic and regulatory activities, environmental health measures and healthy public policies. These latter activities could be said to comprise the structural level sub-themes referred to earlier by Macdonald and Bunton (op.cit.) once again the consensus over what is designated as appropriate health promotion interventions is highlighted. Ewles and Simnett's classification also highlights that health promotion is concerned with both illness and disease, and the enhancement of health and well being, a feature of health promotion also commented on by Downie et al. (1991).

In addition to the widely recognized individual and structural elements of health promotion, some authors have depicted a third strand - that of preventative services such as immunization and screening. For example, Tannahill (1985) proposes that preventative services form one of the three overlapping spheres of health promotion, together with health education and health protection. Thus, activities such as hypertension case finding, screening for handicapping congenital disorders and developmental surveillance are all included in this model of health promotion. Similarly, Ewles and Simnett outline preventative health services as forming a component activity of their health promotion framework and include similar activities to Downie et al. - immunization, family planning and child protection services. In addition, French (1990) also comments on the important place of preventative services in any consideration of health promotion. As Macdonald and Bunton (1992) point out, activities such as screening and immunization services (which they refer to somewhat confusingly as "health protection measures") bridge the gap between the dual pillars of the lifestyle approach and the structuralist approach, since both service provision and behaviour change are involved.

To summarize, the above review indicates that despite the use of different terminology, there is some recent agreement over the meaning of health promotion and the activities or interventions which form constituent parts of it. This comes largely in the wake of the WHO's (1986b) Ottawa Charter for Health Promotion which made explicit the dual structural and individual level at which health promotion operates. Whilst the current practice of nurses in acute care settings is focused predominantly at the level of the individual, this consensus indicates that they should also be cognisant of the structural action aspect of health promotion. An awareness of values associated with health promotion activity, such as holism and participation, would also seem beneficial. This would enable them to communicate effectively with others, based on a common understanding. This would avoid the problem highlighted by Cribb and Dines (1993) that it is possible for individuals to operate with different and conflicting personal models of health promotion which can act as an obstacle to effective communication. An awareness on the part of nurses of the twin elements of health promotion would also avoid the dangers of adopting a reductionist and potentially victim-blaming approach to their encounters with patients.

### **Other Interpretations of Health Promotion**

A number of other interpretations of health promotion have been proposed. Whilst these have largely been discredited and have been superseded by that described above, they are worthy of mention insofar as they relate to the focus of this study. That is, they serve to highlight some of the limitations of alternative conceptualizations. This therefore has implications for nurses who may perceive health promotion in this way and / or base their practice on such interpretations.

### **Health Promotion As All Health Enhancing Activities**

An interpretation which at first seems logical and which has been adopted by some commentators has been to suggest that health promotion refers to any activity designed to promote health. Downie et al. (1991) state that:

“It has (even) been commonplace to use (such) a broad interpretation as to imply that all activities which seek to improve health come under the heading of health promotion” (Downie et al. 1990: 57).

Tones et al. (1990) argue that this is semantically logical and that health promotion in this sense is concerned with all the factors which affect health. Whilst this

interpretation may indeed help to highlight the influence of - amongst other things - social and economic, as well as behavioural, determinants of health, it raises the problem of defining the boundaries of health promotion activities. Cribb and Dines (1993) develop this argument. Building on Seedhouse's (1986) idea that health is the foundations for achievement, they suggest that a bricklayer or a sewage disposal worker may be viewed as being in the business of health promotion in the sense that adequate housing is a pre-requisite to achievement and the production of sanitation contributes to the well-being of society. They further point out that if one enters war to eradicate a tyrannical ruler then it is possible to suggest that such an activity is health promoting in that it strengthens the foundations for achievement in a safer world once the deed is done. Cribb and Dines assert that:

“Such an absurd conception of health promotion demands some boundaries before it becomes a phrase with so broad an interpretation as to become totally meaningless” (Cribb and Dines 1993: 24).

They suggest that these boundaries are best drawn by reference to a set of values consistent with the WHO literature as outlined above. Thus, the parameters centre around a consideration of whether any example of practice is being done in a health promoting way as opposed to the delineation of certain activities as health promotion and the exclusion of others which are not health promoting.

Ewles and Simnett (1992) also highlight the problem of defining boundaries, but suggest that this is necessary in order to determine the limits of service provision by health promotion agencies and in considering courses designed to educate health promoters in the necessary knowledge and skills. They suggest that boundaries can be delineated by distinguishing those things that need to be done to people (such as an appendisectomy or placing a child in a foster home) from those aspects of care and treatment which are about enabling people to take control over their health and improve it. The former activities would be excluded from their definition, whereas the latter would be incorporated as being a part of health promotion. This suggestion is similar to the WHO's statement that health promotion is characterized by collaboration and participation and Cribb and Dines' (1993) emphasis on these as important defining values.

Downie et al. (1991) have also suggested that such an all-encompassing definition of health promotion is unsatisfactory on the grounds that it blurs the necessary differentiation between powerful, established areas of health service provision and

other important and alternative channels for investment. However, this critique is weakened by the fact that it presumes that those established areas (such as hospital and other acute services) are less concerned with the business of health promotion. Cribb and Dines (op. cit.) also comment that Downie et al.'s point is illogical in that the traditional health services' contribution to the elimination of disease is a necessary part of health promotion.

Despite the weakness of Downie et al.'s critique, this interpretation of health promotion as any activity that fosters health does appear to suffer some inherent limitations.

### Health Promotion as Equivalent to Health Education

A second interpretation which also suffers from a lack of reflection on the delineation of boundaries is that health promotion and health education mean one and the same thing. This is widely agreed to have come about as a result of the rise in popularity of the former term in preference to the latter in the 1970s and 1980s and as such may be more accurately described as a chronological shift or a simple substitution of one term for another, with the implication that there is little difference in meaning. A number of authors document that this confusion was exacerbated by the change in title at this time of many Health Education Officers and Health Education Units to Health Promotion Officers and Health Promotion Units without any appreciable change in role or function (French 1985; Downie et al. 1991; Rawson 1992). It is suggested that this may have resulted from their desire to jump on the health promotion bandwagon but that it had the unfortunate result of blurring their specific educational expertise (Downie et al. 1991). To use the terms interchangeably suggests a lack of reflection on the meaning of either and hides the central notion that health is determined by both structural and behavioural determinants, a point which is both historically evident and made clear by the WHO definition above. Therefore to interpret health education and health promotion as meaning one and the same thing not only blurs the educational expertise of some groups of health education specialists, but it may equally be the case that it is used by some groups to overlook the more radical structural changes needed to promote health.

### Health Promotion as the Marketing of Health

A further interpretation of health promotion has been to consider it as a form of marketing or selling health. This is congruent with Cribb and Dines' (1993) analysis of the meaning of the term "promotion". They suggest that one sense of the term derives from salesmanship, in that there may be a promotion for a particular product, whereby



through audio-visual means and persuasive argument customers are encouraged to purchase what is on offer. Tones et al. (1990) also point out that in this manifestation health promotion is the label attached to the marketing of health utilizing the persuasive techniques of mass media and associated promotional tactics borrowed directly from commercial advertising practice. Essentially, such interpretations focus on the meaning of “promotion” in other spheres such as commerce and industry and apply it to the field of health. Williams (1985) cites this approach as being advocated by Cowley (1983) involving a “hard sell” technique and a claim that this is a highly effective way of changing behaviour which can save money and lives and prevent illness and suffering in a much quicker manner than more traditional educational processes. Williams goes on to identify a number of problems with this interpretation of health promotion as “selling” health. First, there are relatively few areas where there exists unequivocal evidence that taking a certain course of action will inevitably lead to health. And the second inherent difference between selling health and selling other goods and services is that with the former, there is often little immediate tangible benefit to the “customer”. She also argues that there are ethical and pragmatic difficulties with this approach and that:

“the very activity of hard sell promotion is in direct conflict with the rational decision-making and personal autonomy which are central to educational, long-term goals, and the two cannot co-exist” (Williams 1985: 32).

Tones (1986) also points out that this approach would be anathema to some health educationalists and inconsistent with the goals of others, although he points out that the use of the media does have a role to play in the promotion of health. Finally, Downie et al. (1991) also condemn this approach as unsatisfactory on the grounds that it misrepresents the “promotion” component of health promotion as consisting of marketing or selling as opposed to enhancing or nurturing health. They suggest that the problem with this is that the importance of high profile mass media inputs is over-emphasized at the expense of sound educational principles. Clearly then, there are problems with accepting this definition or approach to health promotion.

### Health Promotion as Positive Health

A fourth and final interpretation of health promotion which will be considered here is the notion that it pertains to the promotion of positive health and can therefore be contrasted to activities which are designed to prevent disease. Such an interpretation appears to depend on a conceptualization of distinct levels of health and well being at

which it is possible to intervene. As such, there are similarities with the idea of primary, secondary and tertiary levels of prevention as outlined by Moore and Williamson (1984). Nutbeam (1986) interprets the meaning of health promotion in this way, stating that it forms a complementary but separate activity from disease prevention. He writes:

“Disease prevention is essentially an activity in the medical field dealing with individuals or particularly defined groups at risk. It aims to conserve health. It does not represent a positive conception of health that moves ahead, but is concerned with maintaining the status quo. Health promotion on the other hand, starts out with the whole population in the context of their everyday lives, not selected individuals or groups. Its goal is to enhance health” (Nutbeam 1986: 115).

In a similar manner, the US Department of Health, Education and Welfare (1978; 1979; 1980) links health promotion to activities with those who are essentially healthy to begin with and state that it seeks to help them develop lifestyles that can maintain and enhance their state of well-being. Health promotion is contrasted with both “Health Protection” (public health activities such as infectious agent control) and “Preventive Health Services” (services such as family planning and immunization). As Tones (1985) notes, in this context it is seen to be concerned with primary prevention as opposed to the preventive health services which focus on secondary and tertiary protection.

Downie et al. (1991) acknowledge this interpretation of health promotion, stating that it may either be explicit (as above) or implicit - where there is a tendency to write of “health promotion and disease prevention” as an inseparable coupling without making clear the perceived difference between the two.

Although the origins of this interpretation are unclear, Tones (1985, 1986) asserts that the more positive connotations surrounding the term when applied in this way suggest that it may have arisen as a reaction to the negativism which began to surround the alternative term “health education”. That is, health educators had begun to acquire a negative image based on their prescriptive advice and admonitions to people to give up pleasurable behaviours. Tones (1985) says:

“It is hardly surprising then that many practitioners have espoused the positive health cause. They may then describe what they do as Health Promotion rather

than Health Education in order to dissociate themselves from their previous proscriptive past” (Tones 1985: 18).

However, there are two principal problems with this approach to understanding health promotion. The first concerns the fact that the distinction between the promotion of positive health on the one hand, and the prevention of disease on the other, is a somewhat arbitrary one. That is, activities designed to prevent disease or reduce the threat of a disease, such as immunization or screening surely also have the effect of enhancing well being. Similarly, measures aimed at promoting positive health and well being will also incorporate an element of disease prevention. For example, activities aimed at promoting regular exercise could be said to both promote positive health through increased feelings of invigoration and well being, and they would also have a cardio-protective effect, thus helping to prevent disease. Downie et al.’s (op. cit.) criticism of this interpretation of health promotion is based on this difficulty in distinguishing the two spheres of activity. They further suggest that research into what has been done by health promotion professionals and groups reveals that preventative activities such as immunization and screening form a valuable part of their work. This finding forms the basis for Tannahill’s (1985) model of health promotion described above in which health promotion is conceptualized as consisting of both prevention and health protection measures (as well as health education) and aimed at both negative and positive dimensions of health. This appears to be more logical than the US Department of Health, Education and Welfare’s interpretation in which health promotion is artificially separated from prevention and health protection. Cribb and Dines (1993) also comment that this distinction will not bear close examination:

“if health is to be enhanced, this must include its conservation; similarly if well-being is to be maintained, protection against any threats to health will be a crucial part of the process” (Cribb and Dines 1993: 26).

It is also apparent from the foregoing discussion that both the individual and the structural elements of health promotion as conceived by the WHO and others (above) can address equally illness prevention and positive health, thus rendering any artificial separation of the two unnecessary.

A second criticism which can be levelled at this interpretation of health promotion is highlighted by Tones (1986) and centres on the notion of positive health. In addition to inherent difficulties in describing what is meant by positive health, he states that there is

also the possibility that its promotion will lead to “healthism”, a term coined by Crawford in 1980. Tones argues that the latter is a form of victim-blaming in that:

“the self empowered few who manage to achieve exuberant physical fitness, establish meaningful social relationships and succeed in coping calmly and contentedly with self-fulfilling life tasks - these rare beings will inevitably form an elite, distracting attention from the plight of the majority, who find themselves constrained by adverse social circumstances” (Tones 1986: 5).

It is therefore possible that interpreting health promotion in this way could lead to a divisive approach if it is based on a partial understanding of the determinants of health. By ignoring the social and economic constraints to achieving a “positive health” status, it makes the latter obtainable for only certain groups and so in this sense also this notion of health promotion is unsatisfactory.

To summarize, although a number of alternative interpretations of the meaning of health promotion have been proposed, all of these suffer from a number of weaknesses. An understanding of health promotion derived from the WHO’s (1986b) Ottawa Charter represents a more plausible and comprehensive conceptualization of both the strategies, values and principles involved. An analysis of relevant literature reveals that despite the existence of different terminology used by different writers in the field, a degree of consensus has emerged over the meaning of health promotion in the wake of the Ottawa Charter. This suggests that health promotion consists of both structural changes conducive to health and individual education to influence beliefs, attitudes and behaviour. Before considering in more detail the scope of health education at the level of the individual interaction, a brief analysis of the inter-relationship between the broader, structural aspect of health promotion and the role of the nurse will be examined below.

### **The Meaning of Health Promotion: Implications for Nursing**

The work of hospital nurses currently focuses predominantly on individuals and as such nurses’ greatest contribution to health promotion may lie at the level of their health education interactions with patients. However, it is important that nurses are able to conceptualize the broader level at which health promotion operates. This has implications for both the quality and effectiveness of their educational interactions with individual patients, and for their ability to conceptualize ways of working which are complementary to their health education encounters with patients. To take the first

point, nurses will be unable to educate for health effectively unless they have an understanding of the social, political and economic forces that shape peoples' lives and their health choices. Butterfield (1990) develops this argument, suggesting that if nurses do not appreciate the gestalt of populations and societies, they will be unable to develop a basis for analyzing problems when working with individuals or groups. Downie et al. (1991) also state that one of the ingredients of an effective health education approach is a recognition of the structural determinants of health. They suggest that this is important so that the client knows that his perspective is understood and such that the client and educator can plan ways of overcoming any barriers. Delaney (1991) also comments on the need to be cognisant of health promotion's concern with the environment, arguing that in the context of disease management advice nurses should be aiming to produce an environment and social context which supports and facilitates such management. A final reason why nurses need an understanding of the wider determinants of health to inform their interactions with patients is highlighted by both Maglacas (1988) and DeLa Cuesta (1991). They suggest that one of nursing's functions in the achievement of Health For All 2000 is to enable and empower people to improve their environments and become a force for positive social change, which would help to solve or lessen wider inequalities in health. Clearly, if nurses are unaware of the social and structural level at which health promotion operates, they are unlikely to be able to work towards these objectives.

As outlined above, nurses also need to understand the policy and structural element of health promotion in order to have the vision required to develop their role in this direction. A number of authors have commented on the need for nurses to expand on traditional ways of working if they are to fulfill their role in health promotion. For example, Maglacas (1988) outlines a role for nurses in creating health care environments that sustain and promote healthy living. This is congruent with the Government's recommendation in the recent Health of the Nation (1992) White Paper that the NHS should be aiming to create health promoting workplaces. With specific reference to the role of hospital nurses, Tones (1993) also comments that hospitals must have sound health promoting policies. He suggests that assertiveness should form part of nurses' repertoire of skills in order to support their health promotion function. Delaney (1991) also highlights a role for nurses in the formation of local policies which influence health. She states that whilst there is less focus currently in nursing on addressing structural influences, nurses can nevertheless have an impact on policies. Delaney advocates that legitimate activities for nurses in this respect include reading the local press, as well as professional journals and involvement in local health related organizations.

Maglacas (op. cit.) also outlines the need for nurses to not only understand the agendas and priorities of key decision makers, but also to become more effective communicators with such groups in the interests of having an impact on policies which influence health. Further, in line with the WHO principles, Maglacas proposes a role for nurses in advocacy and mediation in relation to shaping and building healthy public policy.

A final point, related to the above, is the growing consensus in the literature that nurses need to be more politically aware. A number of commentators (for example Coxon 1986; Maglacas 1988; Cowman 1989; Williams 1989) have suggested that engagement in political activity by nurses is necessary if they are to fulfill their health promotion role. This reflects a recognition that health promotion is inevitably political because it aims, for example, to eliminate inequalities in health and to encourage social action for change. The idea advocated is that a more political role for nurses should complement their health education role in interaction with individuals.

If any of the above recommendations are to be accomplished then it is essential that nurses have a sound understanding of the meaning of health promotion, including the structural level at which changes for health can be made. It would appear that an interpretation of health promotion which is based on the emerging consensus in the literature (reviewed above) would provide an appropriate framework for nurses to develop their role, both at the level of the individual interaction and in a consideration of complementary approaches to this. It is apparent from the above review that nurses' adherence to alternative interpretations of the meaning of health promotion would result in limited perceptions and vision about what their role could entail. As a consequence, this would be likely to constrain the development of practice. In addition, a lack of recognition of the meaning of health promotion would have implications for nurses' ability to communicate with others engaged in health promotion work.

As was made clear above, the focus of nurses' work currently lies with individual patients and as such nurses' perceptions and practice of health education forms a central focus of this study. Therefore a more detailed examination of this concept is warranted, which helps to illustrate the potential role for nurses in acute care settings.

### **The Scope of Health Education Information**

The preceding section makes clear that there is currently some agreement that health education comprises a component of the broader concept of health promotion. This is evident from an examination of the widely accepted WHO Ottawa Charter which

outlines the “development of personal skills” as one aspect of health promotion. The necessity of both structural and individual changes in the interests of health is apparent in the models and definitions of health promotion reviewed above. In the light of this, Rawson (1992) has recently stated that:

“Most writers now appear to have accepted that health education is re-defined as part of a broader health promotion perspective” (Rawson 1992: 204).

From the historical perspective reviewed above, it is clear that the traditional function of health education is to influence the actions, behaviours or choices that individuals make such that it is more likely that these enhance, rather than diminish, health. Whilst this remains an important function of health education, other aspects have also been identified. These are reviewed below in order to outline the types of health education information that nurses may be involved in sharing with patients.

#### Information About Preventative Services

The first of these is that health education can comprise education or information to individuals about the appropriate use of health, and other, services likely to enhance health or prevent disease. This has been identified by a number of writers, although once again, different terminologies mask a similar idea. Beattie (1991 p164) cites Tuckett’s (1979) classification of three different rationales for health education as one of the earliest attempts to distinguish the various types of content it may cover. In addition to health education designed to produce changes in beliefs and behaviour in order to reduce morbidity and mortality, Tuckett asserts that it also aims to influence norms and values governing the use of health services. A similar idea is found in the two classification schemes proposed by Draper et al. (1980) and Draper (1983). He also identifies not only education about the body and how to look after it as a component of health education, but also provision of information about access to and appropriate use of health services. This implies a somewhat coercive, paternalistic process and assumes that the services available are indeed appropriate, accessible and will result in better health if used. This idea is developed further by Downie et al. (1991). They cite Tannahill’s (1985) model of health promotion, in which the term “preventive health education” is used to refer to educational efforts to influence lifestyle in the interests of preventing ill-health as well as education aimed at increasing the uptake of preventative services. However, Downie et al. (op. cit.) point out that:

“the two-way nature of the educational process must not be forgotten; communication channels must be used to ensure that appropriate (wantable) preventive services are provided” (Downie et al. 1990: 58).

Thus, one aspect of the nurse’s health education role in acute care settings may be to provide information about relevant preventative services and to encourage feedback from patients on the relevance and appropriateness of such services. This type of health education relates to a component of health promotion described earlier - that is, the provision of preventative services.

### Information about the Structural Determinants of Health

Other types of health education have also been proposed which have an identifiable link to the structural determinants of health, or the broader perspective which health promotion is believed to encompass. Several writers suggest that health education can include informing or educating individuals about the wider social and economic determinants of health. This highlights the importance of nurses being cognisant of this aspect of health promotion, as outlined above. In Draper’s (1983) classification scheme mentioned above, two of the five types of health education identified are consistent with this idea. He describes (i) education about the environment and how this influences health and (ii) education about the politics of health and impotence and disadvantage, as two forms of health education. Similarly, French (1990) asserts that health education should be concerned with ensuring that high quality information is available to all those who require it and, that this should include information about the social and economic determinants of health. French does not make the importance of this activity explicitly clear and/or elaborate on the way in which health education of this type may contribute to the promotion of health. Indeed, it could be argued that such information in isolation without a consideration of how to overcome structural barriers to health choices would have a disempowering and therefore a negative effect on health. However, some clue as to the purpose of providing information of this nature is evident in his suggestion that health education is about enabling people to set their own agendas that they themselves can implement in ways decided by themselves, either individually or collectively. Presumably then, informing people about the social and economic determinants of health would act as a precursor to them taking appropriate action on these if they felt it necessary. Tones et al. (1990) also identify raising awareness of circumstances and environments and how these influence health as one aspect of health education and specify how this may contribute to action on the wider determinants of health at the level of health promotion. Borrowing from Friere’s (1968) notion of



“conscientization”, they label health education which aims to help people critically examine their lives, circumstances and environment in which they live as “critical consciousness raising”. They further suggest that individuals or groups of individuals:

“should then take action as a community and pressure politicians into implementing policies which they might find not only financially damaging but also ideologically distasteful” (Tones et al. 1990: 5).

In short, education at the level of the individual may result in structural changes to improve health via information and awareness raising during health education interactions. Nurses’ role in the provision of this type of information has been intimated by, for example, Maglacas (1988) who suggests that nurses need to develop new skills in enabling and empowering patients to achieve environmental improvements conducive to health. DeLa Cuesta (1991) also argues that, by adopting an enabling approach to interactions with clients, nurses can promote collective action to tackle health issues. Presumably, this would involve raising awareness of the wider, structural determinants of health and as such can be taken as a further aspect of nurses’ health education role.

### Agenda Setting

A second form of health education which involves awareness raising of wider health issues, but which is less radical in intent than critical consciousness raising, is identified by Tones et al. (1990) as “agenda setting”. This also plays a part in wider policy changes influencing health and acts as a precursor to the same. Tones et al. suggest that agenda setting works by paving the way for legislative and other measures which potentially infringe individual liberties through raising individual awareness of the issues in question. They suggest that since legislative measures:

“will normally involve some infringement of individual liberty, those whose liberty has been thus threatened may have to be softened up by precursor education before politicians - national or local - might be willing to take potentially unpopular actions.” (Tones et al. 1990:5)

The example of seat belt legislation is given, in that although education alone was unsuccessful in significantly reducing death and disability from road accidents, the education served to pave the way for acceptance of the legislation which followed.

Despite the difference in terminology, a similar idea is incorporated into Tannahill's (1985) model of health promotion. In what he rather laboriously terms "health education for preventive health protection" and "health education aimed at positive health protection" is the suggestion that education can be useful in ensuring the success of legislative actions to either prevent ill health or promote positive health. Tannahill states that efforts to create a social environment conducive to the success of legislative measures are important (through raising awareness and securing support) and he also gives seat belt legislation as an example of this process. Tannahill does not comment on the potentially coercive nature of this type of health education, but does suggest that it should involve not only the public at large, but also policy makers.

This therefore highlights a further type of health education information that might characterize nurses' interactions with both patients and policy makers where appropriate. This referral to policy makers highlights a final variety of health education to be discussed here.

#### Education of Professionals and Policy Makers

Both Tones et al. (1990) and Downie et al. (1991) suggest that health education should involve communicating not only with members of the lay public, but also with those who hold responsibility for making decisions or creating policies which influence health. Tones et al. label this "professional education" and propose that it is another educational strand which contributes to the overall health promotion process. More specifically, they state that it has the twofold aim of (i) persuading decision-makers to assume health promoting responsibilities and (ii) facilitating the delivery of services which would meet community needs. Similarly, in recognition of the fact that overall responsibility for health does not rest with members of the lay public alone, Downie et al. (op. cit.) define health education as communication activity which works through:

"influencing the beliefs, attitudes and behaviour of those with power and of the community at large" (Downie et al. 1991: 28).

They suggest that the power holders include politicians, industrialists and other businessmen, and professionals within and outside the health service.

As outlined above, some commentators, notably Maglacas (1988), suggest that nurses have a role to play in health education of this nature. She outlines the necessity for nurses to be involved in communicating with such individuals, using information and

marketing techniques. This therefore highlights a further potential aspect of the nurse's health education role.

In summary, it can be seen that health education encompasses a number of forms or types of content in addition to its traditional role of influencing the health choices and behaviours of individuals. It may be concerned with information about the use of health services, raising awareness of the wider influences on health (as a precursor to community action and legislative measures) or the education of key policy makers. These latter forms suggest that health education can make an important contribution to health promotion which is considered to act at a structural level. It also makes clear that there are a number of different types of health education information that nurses may be involved in, in addition to information about health choices, behaviours and lifestyles. A more thorough examination of the different approaches to health education - that is, different models and the values and ideological assumptions underpinning these - follows below.

### **Models of Health Education and Their Relevance to Nursing Practice**

There have been numerous attempts to describe approaches to, or models of, health education. Rawson and Grigg (1988) for example, identified at least 17 different taxonomies of health education models in an overview of the relevant literature. The resultant confusion and lack of clarity has been to some extent caused by the fact that some earlier attempts to describe health education really reflected attempts to broaden its boundaries to include social and structural interventions. These conceptualizations have subsequently been superseded by the recognition that the term health promotion more accurately describes these structural type of interventions to improve health (see above). The confusion and contention has been further exacerbated by the failure of many writers to build on previous work and acknowledge similarities. There is little cross-referencing, critical appraisal or cumulative building of ideas (Rawson 1992). Caplan (1986 cited in Taylor 1990) also notes that people frequently use different terms or adjectives to describe similar health education situations or processes such that important similarities between health education models appear as differences. He relates this situation to the fact that many models fail to move from a descriptive to a theoretical level, a point which has also been commented on by others (Gott and O'Brien 1990; Beattie 1991; Rawson 1992). This has led to some attempts to trace the theoretical and ideological underpinnings of some of the health education models proposed, although this remains a recent and incomplete development to date. For the purposes of this study, an overview of the similarities of some of the most recent and

more developed typologies of health education was undertaken, and an examination of the ideological basis and effectiveness of different types (where this is known) follows below. This enables some consideration of the most appropriate approach to health education applicable to nurses working in acute care settings. Broadly, two distinct models of health education can be identified from the literature, and these are termed here “the behaviour change model” and “the self empowerment model”.

### The Behaviour Change Model

A review of the literature indicates that this approach to health education has been identified by a number of different writers, using different terminologies. For example, Tones et al. (1990) refer to this model of health education as “the preventive model”; Downie et al. (1991) depict a chronological shift and refer to it as “the traditional approach”; Ewles and Simnett (1992) refer to similar characteristics under the headings of “the medical approach” and “the behaviour change approach” and French and Adams (1986) also label essentially similar ideas as the “behavioural change model of health education.”

Similar features or characteristics of this approach are depicted by various writers, many of which arise due to the fact that this model is believed to be a derivative of the medical model which has traditionally characterized medicine in the 20th century. Beattie’s (1991) identification of “health persuasion tactics” as one strategy of health education bears close similarity to the behaviour change model and he suggests that its historical roots can be traced to the temperance campaigns of the 19th century and the anti-VD propaganda at the time of the 1914-1918 war. Vuori (1980) also traces the marriage of health education and medicine, arguing that the origin of the latter’s supremacy can be traced to the era of the Enlightenment and the Scientific Revolution of the late 19th and early 20th century. The ties between medicine and health education grew stronger during the Enlightenment when philosophers believed in the concept of the perfectability of man by means of education and later the theory of specific aetiology supplied medicine with the means to establish its supremacy. Vuori writes:

“In this atmosphere, filled with confidence in further medical triumphs in the future, it was more than natural that health education, already inseparably tied to medicine, was relegated to the position of a handmaid of medicine, borrowing its content from its master” (Vuori 1980: 17).

Tones et al. (1990) also note that what they refer to as “the preventive model” is derived from the “widely accepted and understood” medical model. Thus, the origins of the behaviour change model dictate that it possesses certain characteristics and assumptions, some of which form the foundations for the criticism which has been levelled at it (see below).

### Ideology of the Behaviour Change Model

It has been argued (Gott and O'Brien 1990; Beattie 1991; Rawson 1992) that the ideological and theoretical basis of health education and health promotion has been insufficiently developed and that interventions and practice have preceded any theoretical rationale rather than developing as a consequence of it. Nevertheless, there have been some attempts to explore the ideology underpinning the various models or approaches to health education and health promotion.

In view of the behaviour change model's focus on the individual as the legitimate target of health education activity (see below), it is perhaps not surprising that it has been identified with an ideology which emphasizes individual endeavour and competitiveness (Tones et al. 1990). Navarro (1976) for example, asserts that it strengthens the tenets of bourgeois individualism. Similarly, Williams (1989) states that this form of health education is derived from classical liberal theory which is based on assumptions congruent with an “individualistic self-care behaviour approach to health promotion”. Williams states that these assumptions have to do with abstract individualism, rationalism and egoism such that;

“Society is conceptualized within classic liberalism as a network of voluntary human associations that results from free choices of rational individuals based on calculations of personal gain” (Williams 1989: 16).

Such a view of society is clearly congruent with the characteristics of the behaviour change approach to health education described below. Beattie (1991) also highlights the individualist ideology underpinning what he calls “health persuasion techniques” by mapping out contemporary health promotion strategies on a structural map composed of two bi-polar dimensions. As described earlier, the dimensions of cross-classification used to locate different strategies are: “mode of intervention” (authoritative versus negotiated) and “focus of intervention” (individual versus collective). Beattie suggests that the technique of health persuasion (which seeks to change individuals' behaviour) is authoritative in its mode of intervention and has the individual as the focus of

intervention. Taylor (1990) describes other aspects of the behaviour change model's underlying ideology. She develops the framework used by Whittington and Holland (1985) to represent theoretical perspectives of social work and suggests that these can be applied to health education. The four perspectives identified are generated from two dimensions: the first concerns the nature of knowledge (ranging from subjective approaches to understanding through to objective approaches) and the second relates to assumptions concerning the nature of society (ranging from theories of radical change to theories of social regulation). What Taylor describes as the traditional perspective (which aims to ensure behaviour and attitude modification) is based on an objective approach to the nature of knowledge and a view of society which emphasizes social regulation.

Thus, some of the ideological principles underlying the behaviour change approach to health education become clear. These principles illustrate further the model's close alignment with medicine, a tradition also founded on ideas such as the objectivity of knowledge, rationalism and the isolation of man from his environment. These ideas are contrasted to those underpinning alternative approaches to health education later in this Chapter.

#### Limited Focus of the Behaviour Change Model

As the label suggests, the goal of this approach is to foster changes in individual behaviour which are conducive to better health (Vuori 1980; French and Adams 1986; Taylor 1990; Tones et al. 1990; Downie et al. 1991; Ewles and Simnett 1992). The literature implies that this aim may be achieved through action at the one to one level, or, as Beattie (1991) discusses, it may involve health persuasion via the use of mass media campaigns. Nevertheless, the focus or the target of the activity is always the individual and his or her behaviour. It has also been pointed out that the focus is on physical health (as opposed to mental and social aspects) and freedom from medically defined disease. For example, Downie et al. (1991) state that the emphasis is on prevention rather than positive health, and:

“The main emphasis is on *physical* aspects of ill-health. This is reflected in the information base used, which represents a highly limited medical perspective” (Downie et al. 1991: 33) (original emphasis).

French and Adams (1986) also suggest that the behaviour change approach is concerned exclusively with “optimum biological functioning and role performance” and

Ewles and Simnett (1992) propose that the aim (of the medical approach) is freedom from medically defined disease and disability. The emphasis of the behaviour change approach then, is on the prevention of physical ill-health, as opposed to the enhancement of positive health and well-being and as such this represents a limited and rather negative focus to health education. Both Tones et al. (op. cit.) and Vuori (op. cit.) also associate the model's goal of disease prevention with a sub-goal of proper utilization of health services. This has been commented on earlier in relation to the different types of health education content which are possible - in the behaviour change approach, the goal is a coercive one, rather than a two-way flow of information about the appropriateness and effectiveness of services. Vuori states that the main task of this approach is to direct consumers to use "properly" the available health services, without questioning their relevance and effectiveness. This therefore has implications for the extent to which services are appropriate and responsive to need and, coupled with the limited objectives of this approach, suggests that nurses would be limiting their potential by adopting this model of health education.

### Rationality of Man

According to Downie et al. (1991), a principal assumption of the "traditional approach" to health education is the expectation of a linear or orderly sequence beginning with the provision of knowledge, and which is presumed to result in a change of attitudes and on to a consequent change to medically defined "correct" behaviour. The resultant behaviour is presumed to have the desired effect of preventing physical ill health in individuals. Implicit in this sequence of events is the simplistic notion of the rationality of man. French and Adams (1986) also highlight that the behaviour change model is guided by a model of humanity wherein man is regarded as a rational decision maker and a mechanistic animal. Williams (1989) also comments on the notion of rationality: she cites Wright (1982) who proposes that one feature of rationality is the conceptualization of the capacity to reason as a purely mental faculty that is separate from physical and emotional aspects of the individual and from the realities of context. Williams also states:

"Human reason is conceived of as a consciously deliberate process of dispassionate, intellectual means-end calculations, a process that is insulated from the influence of values. The belief is that facts speak for themselves and that a complete set of facts, insulated from emotions and values and properly arranged in relation to each other, will reveal the truth" (Williams 1989: 16).

She goes on to suggest that what she refers to as “individualistic health promotion” (which she says is characterized by practice and programmes that concentrate on changing individual behaviours) reflects these assumptions of rationalism. Clearly, the assumption of man as a rational being is a somewhat simplistic and deficient account of the realities of behaviour and therefore nurses' perceptions and practice of health education would be limited by adherence to the behaviour change model.

### Illusory Freedom of Choice

A further assumption implicit in the linear sequence of knowledge, attitudes and behaviour change is the idea that the individual who is the recipient of the information or knowledge is free to choose his actions or behaviours. Both Downie et al. (1991) and Williams (1989) note that in this model of health education, freedom of choice, or the idea that the individual has sole power to control his or her behaviour, is assumed. To a certain extent, the notion of freedom of choice is related to the presumed rationality of man - that is, that individuals' behaviour is unfettered by emotions and values. However, such an assumption also ignores wider, social and economic determinants of health and the model has also been criticized for this reason. As stated above, most writers agree that the focus of the behaviour change model is on the individual and his or her behaviour in isolation from the social context. The underlying assumption is therefore that the main (or only) determinant of an individual's health status is the individual's behaviour, which he/she is freely able to choose. The fact that this contradicts much of what is known about determinants of health status has been highlighted as a major weakness of this model. For example, French and Adams (1986) justify placing the behaviour change model at the bottom of a hierarchy of three health education models on the grounds that:

“there is growing evidence to contradict the assumption that individual behaviour is the primary determinant of health status. Whilst it is true that habits like lack of exercise, cigarette smoking, over-eating or excess alcohol consumption do lead to death and disability, research suggests that more basic social, economic and environmental factors are both the direct cause of some diseases and important determinants of the health damaging behaviour that leads to other illness” (French and Adams 1986: 72).

They go on to quote a variety of research studies which suggest that circumstances such as social stress and economic crisis have all been linked with outcomes such as cardiovascular disease, cancer and accidents. The model's failure to take social and



economic determinants of health into account has also been highlighted by Vuori (1980), Williams (1989), Downie et al. (1991), Tones et al. (1990) and Ewles and Simnett (1992). The idea that the individual determines his/her health status through freely made choices is inevitably linked to the assumption by advocates of the behaviour change model that individuals are therefore responsible for their own health behaviour and consequent health status. These rather simplistic notions contradict research evidence such as that contained within The Black Report (1980) and The Health Divide (Whitehead 1987) which links health and illness to broader issues such as poverty, education and employment. This has led to a critique of this approach to health education on the grounds that it is “victim blaming”. Tones et al. (1990) cite Crawford’s (1977) and others’ application of the notion of victim blaming to this model, and suggest that in doing so they are:

“claiming that it is not only inefficient but manifestly unethical to blame the victim for adopting an unhealthy lifestyle when society itself engenders and sustains the very unhealthy habits which health education seeks to eliminate” (Tones et al. 1991: 9).

In a similar vein, Vuori (1980) also comments that there are ethical problems with this approach. He states that health choices are determined by society rather than individual knowledge and attitudes and that the ethical problems arise when individual health education is not backed up by social support for the desired options. This therefore highlights a further reason why nurses should avoid aligning themselves with this model of health education.

### Imposition of Values

A further characteristic of the behaviour change approach to health education is that there is a presumption that knowledge, values and attitudes about health are neutral entities that can be pre-defined and similar conceptions are held by the imparter and the receiver of the health education message (Vuori 1980; French and Adams 1986; Taylor 1990). Vuori, linking the assumptions of the medical model to health education derived from it, argues that as biological knowledge is regarded as neutral and value-free, as a consequence this form of health education is also considered to be neutral and the essence of it is to disseminate knowledge produced by medical research. Discussing the “traditional perspective” of health education, Taylor (1990) highlights a similar point. She says:

“Characteristics attributable to this model include the belief that experts know what is best for the public. This belief justifies the use of didactic or coercive methods. It is assumed that professionals and lay persons share values relating to health, while ownership of the appropriate health education knowledge lies with the experts” (Taylor 1990: 13).

The corollary of this is that communication, or information-flow is one-way, from expert to recipient, and the recipient’s contribution to the interaction is neither sought or valued. This results in prescriptive and professionally determined patterns of communication.

Perhaps not surprisingly, this assumption has also led to criticisms of the model on ethical grounds. For example, Ewles and Simnett (1992: 33), point out that there is a danger of imposing alien values on a client and that, “frequently this is the imposition of white, middle-class values on working-class people.” Clearly then, there are ethical issues involved if nurses assume that one set of values is “right” and attempt to impose these on patients.

#### Ineffectiveness of the Behaviour Change Model

A final criticism of the behaviour change approach to health education is perhaps a result of the weaknesses described above - that is, there is no evidence to suggest that it is effective in producing behaviour change conducive to health. Naidoo (1986) states that one of the major criticisms of what she terms “individualistic” health education is that it is not effective within its own terms of reference. Similarly, French and Adams (1986) point out that behaviour change methods have had little success in bringing about lasting behaviour change and consequently decreases in morbidity and mortality. Discussing the use of health persuasion techniques as a form of health education, Beattie (1991) also states that:

“Review of research on the effectiveness of this strategy (however) have repeatedly shown that it is for the most part strikingly unsuccessful, on its own, in bringing about changes in lifestyles (Gatherer et al. 1979)” (Beattie 1991: 169).

With reference to mass media campaigns which aim to persuade individuals to change their behaviour, Beattie explores the reason for the persistence of this approach in spite of the “solidly founded conclusion” regarding its ineffectiveness. He suggests that it

has obvious attractions of being a visible and straightforward means of intervention which is simple to plan. He also argues that government departments and powerful others with vested interests have consistently placed an over-emphasis on mass campaigns and have avoided more wide-ranging health promotion initiatives. Therefore, if the behaviour change model is ineffective, this provides a further reason why nurses should avoid adhering to any of the characteristics of this approach, either in principle, or in practice.

### Implications for Nursing

Historically, the nursing profession has had a tendency to align itself with the medical model of care, and has allowed nursing practice to be characterized by its principles. It is only comparatively recently that nurses have moved to embrace more individualized and holistic approaches to care. However, in the light of the above limitations, it would seem important that nurses have not adopted an approach to health education which is derived from this bio-medical perspective. It is apparent that this would serve to limit their potential role in health education due to the model's narrow focus and its questionable ethics and effectiveness. In the nursing literature, several writers have highlighted the dangers of approaching health education in this way. For example, Delaney (1991) expresses the concern that the nurse's educational role should not be simply concerned with telling patients what to do. Coxon (1986) also points out that using didactic methods risks offending patients or relatives by making them feel guilty or angry, and eroding their confidence and thus ensures failure of nursing objectives. De La Cuesta (1991) suggests further disadvantages of nurses approaching clients' health needs in a victim blaming or impeding, paternalistic manner. She states that ultimately this leads to dependency, and adjustment and acceptance of adverse health situations such that inequalities and disparities in health are perpetuated and maintained. Whilst there is little direct reference to a behaviour change model in such statements, it is clear that nurses are being cautioned to avoid characteristics of this approach.

To summarize, a review of the literature indicates that a particular approach to health education can be identified which is termed here "the behaviour change model". It is characterized by a focus on the individual and the health educator's aim is to transmit knowledge which will lead to the desired attitude and behaviour change in order to enhance the individual's physical health. A number of assumptions are incorporated - for example, that man is a rational being who is free to choose his own behaviour and is thus responsible for his own health. These implicit assumptions have been criticised on the grounds that they are simplistic and contrary to research evidence about health

and its determinants. As a result, the behaviour change approach to health education is widely recognized to have clear limitations. As French and Adams (1986) conclude:

“health education which aims to change personal behaviour has serious flaws. It is often based on a superficial analysis of what causes health and disease; it is based on dubious ethical assumptions; and it has not been shown to be a particularly effective strategy for public health” (French and Adams 1986: 73).

It is therefore clear that if nurses’ perceptions and practice are derived from the behaviour change model, this is likely to limit their potential for promoting the health of those patients with whom they work.

### The Self Empowerment Model

An alternative approach to the behaviour change model has also been described in the health education literature. Although its focus remains at the level of the individual, it is based on a different set of premises from the model outlined above, and differs in its aims and the methods and processes by which education for health is achieved. A review of the literature reveals that although different terminologies abound, a discernible model of health education, based on the principle of empowerment, can be identified in the work of several writers in the field of health education and health promotion. An overview of the characteristics of this model, together with some discussion of its underpinning ideology, and its effectiveness and acceptability to nurses and other health educators and is given below.

An approach to health education based on self empowerment is frequently contrasted to the behaviour change approach in a number of health education typologies or frameworks that have been described. For instance, both Tones et al. (1990) and French and Adams (1986) describe “self empowerment ” models of health education and compare these to “preventive” and “behaviour change” approaches respectively. Similar ideas can be found in the element of Beattie’s (1991) typology which he refers to as “personal counselling for health”. Empowerment is also a central feature of Downie et al’s (1991) “modern approach” to health education and can be identified too in Ewles and Simnett’s (1992) description of “educational” and “client centred” approaches.

Tones et al. (1990) suggest that whilst the preventive (behaviour change) approach is derived from the medical model of care, the self empowerment approach is based on an educational model. That is:

“This model is consistent with the view of those philosophers who argue that education is a very different process from other attempts to influence people - such as propaganda, persuasion, instruction, training or any other non-rational methods which either rely on coercion in different degrees or give no thought to the moral nature of the outcome of the learning” (Tones et al. 1991: 11).

As Tones et al. (op. cit.) state, a fundamental issue governing an approach based on educational principles is the notion of informed choice - that is, that the educator is concerned with enabling individuals to make choices based on possession of the relevant information or knowledge. Thus, the coercive nature of the behaviour change approach is considered unethical. However, the notion that the provision of information results in the ability to make an informed choice has been criticized on the same grounds as the behaviour change approach in that the concept of free choice, at least for some individuals, is illusory. The ability to choose freely can be constrained by psychological barriers (e.g. feelings of powerlessness), socio-environmental factors (e.g. lack of finances or social support) and/or the problems of addictive behaviours - as McKeown (1976) states, with a drug of addiction the option is open only at the beginning. Thus, although the self empowerment model is derived from educational principles which emphasize informed choice, it relies on more than the mere provision of information for its success. Beattie (1991), discussing the “personal counselling for health” approach to health promotion makes clear that this encompasses more than education via the provision of information. He states that,

“The cluster of theories and methods associated with this line of work have their origins in psychodynamic and post-Freudian humanistic psychology and social psychology” (Beattie 1991: 173).

Thus, the self empowerment model of health education is considered to be based partly on an educational model and also draws from humanistic and social psychology theory. The features which characterize this approach and their implications for nurses are outlined below.

### The Necessity of Clarifying Beliefs and Values

Both Tones (1987) and Downie et al. (1991) propose that this model of health education involves helping people to clarify their beliefs and values in relation to themselves, health, and health influencing behaviour. The theoretical rationale behind this follows the work of theorists such as Fishbein (1980) (cited by Tones 1987) who proposes that attitudes (that is, the feeling of importance attached to any given course of health action) result from a complex of beliefs. Therefore, an exploration of beliefs is a precursor to modifying attitudes such that they are more consistent with healthy choices and behaviours. Tones (1987) also comments on the importance of clarifying beliefs and values in order to ensure that these are consistent with the realities of health and illness such that informed choice is possible. He cites research by Tuckett et al. (1985) which demonstrated that patients failed to follow doctors' advice because the latter's recommendations were not compatible with the patients' "theories of illness" or their beliefs about the difficulties involved in following the recommendations. This highlights the importance of nurses eliciting patients' beliefs about health and illness issues in order that any health education advice offered is appropriate and acceptable to them. This is recognized by, for example, Mitchell (1989) who suggests that nurses as educators must use their expertise in helping clients clarify thoughts and beliefs about health.

### Empowerment and Its Associated Characteristics

With more specific reference to the point that information alone is insufficient to enable free choice, recent assertions about the aims of the self empowerment model of health education emphasize the importance of control, autonomy and decision-making such that the ultimate goal of freedom of choice is facilitated (French and Adams 1986; Tones 1987; French 1990; Tones 1991). It is suggested that the obstacles to free choice can be overcome through an educational process that involves both self empowerment and what has been referred to earlier as "critical consciousness raising." With regard to self empowerment, Tones (1991) defines this as:

"the process whereby an individual - or a community of individuals - acquires power, i.e. the capacity to control other people and resources. Self empowerment focuses on the individual's capacity to control his or her own life" (Tones 1991: 18).



Thus, labelling this approach as a “self empowerment” model of health education aptly reflects its concern with the notion of fostering control such that freedom to make choices, based on information, is possible. Advocates of this model believe that the way in which this goal can be achieved is through the development of various personal skills and resources. Whereas the behaviour change model rests on the naive assumption that there is an orderly progression from the simple provision of information to changes in behaviour conducive to health, the empowerment approach regards an individual’s health behaviour as a product of more complex psychological and social factors, congruent with the theory and principles from which it derives (see above). However, although there is a growing body of literature advocating the importance of self empowerment as a means of enhancing the health of individuals, there is surprisingly little detail about how this may be accomplished and/or its relationship to health status. In a series of papers, Tones (1987; 1990; 1991; u.d.) provides an almost exclusive account of this process, and an overview follows below.

Tones’ account of the process whereby individually-focused education can promote health through the process of self empowerment (and critical consciousness raising) can be seen as a response to the criticism that has been levelled at approaches that intervene at the level of the individual. As described above, opponents have argued that these are victim blaming and ignore the structural determinants of health and disease. Whilst this may be true of behavioural change approaches to health education, Tones (1987; 1990; 1991) argues that education targeted at individuals remains a necessary component of health promotion and, through offering the opportunity for empowerment, avoids the problem of victim blaming. He suggests that there are a cluster of characteristics associated with empowerment, all of which are related to the concept of control. The first of these is the notion of self-efficacy and the related idea of locus of control, both of which are concerned with beliefs about control. Tones (1991) suggests that self-efficacy concerns the extent to which individuals believe that they are capable of achieving the effort involved in a health related behaviour or outcome. The implication is that the higher the degree of perceived self-efficacy, the more likely it is that an individual will achieve the desired health outcome. Whereas self-efficacy beliefs are specific to given behaviours and outcomes, locus of control refers to more generalized ideas about the nature of control and individuals are differentially distributed along an internal-external dimension of perceived control. As Tones (1987) points out,

“The application of the notion of locus of control to the health field has been extensively researched. External locus of control has been associated with sickness while “internality” has been correlated with non-smoking, greater

likelihood of contraceptive use, weight loss, greater seat belt usage and inoculation against influenza” (Tones 1987: 24).

An internal locus of control is therefore more likely to result in health enhancing behaviours, if coupled with a perceived self-efficacy about one’s ability to carry out the desired behaviours in a given situation. Tones (1991) suggests that self-efficacy is central to the notion of self empowerment. By implication therefore, adopting a self-empowerment approach to health education would involve nurses in attempts to foster a belief in the self-efficacy of the individual or group of individuals with whom they are working.

A second characteristic related to self empowerment and the capacity to make decisions is self-esteem. Enhanced self-esteem can be considered to both derive from, and contribute to, self empowerment. Tones (1991) elaborates on the way in which it can contribute to health and well being. He comments that it is associated with health in an obvious way, as it is an attribute of mental health in its own right, and respecting and valuing oneself (i.e. the possession of high self-esteem) is likely to result in a desire to look after oneself. Less obviously, Tones argues, people with high self-esteem: are more likely to be able to resist social pressures to conform to unhealthy behaviours; are better able to cope with levels of anxiety generated by health threats (as opposed to indulging in defensive avoidance behaviour) and they will be less able and willing to tolerate the cognitive dissonance resulting from engagement in unhealthy behaviours or failure to adopt healthy ones. Following this line of argument, it thus becomes clear that the promotion of self-esteem as part of the self empowerment approach to health education, is more likely to result in the individual adopting health enhancing behaviours. From this it is also clear that this model is concerned with more than physical health and disease - it also addresses mental health and assumes that the two are inter-connected.

Tones (1987) describes lifeskills as “the final element in the cluster of characteristics associated with self empowerment” and suggests that these have the dual function of enhancing internality and self-esteem and providing the tools that enable people to take decisions, influence other people and generally have an impact on the environment. They therefore constitute a further important feature of the self empowerment model of health education. Others have also commented on the importance of the acquisition of lifeskills in the process of education for health (WHO 1986b; Beattie 1991; Downie et al. 1991). Examples of relevant lifeskills include relationship-building, time management and assertiveness (Tones 1987) and confidence building, self-assertion,



decision-making, action planning and contract making (Kanfer and Goldstein 1975). Clearly, the acquisition of such skills is not only likely to contribute to feelings of health directly, but also to self empowerment and the ability to make decisions about health behaviours. Tones et al. (1990) suggest that lifeskills such as stress management or coping with unemployment are goals directly related to health, but in their view more important is the way that lifeskills may contribute positively to the way in which individuals view themselves. For instance, they propose that:

“teaching people how to be assertive, to communicate effectively and to be positive about themselves, not only provides them with useful social skills to facilitate choice, but also promotes personal growth” (Tones et al. 1990: 13).

Once again, implicit in this is the notion that mental and social aspects of health are important in addition to physical components.

Little has been written specifically about the nurse's role in helping people acquire lifeskills. However, in the context of the nurse's role in health promotion, Mitchell (1989) suggests that nurses need to use their expertise in helping clients develop skills in decision making and Maglacas (1988) recommends that nurses need to develop skills in promoting people's coping abilities in order to maintain their health. This therefore suggests that teaching certain lifeskills should also form a part of the nurse's repertoire of health education skills in interactions with patients.

Thus, a number of inter-related notions characterize the self empowerment approach to health education. Essentially, they are based on the idea that health choices depend on the ability to make decisions and to exert control over one's destiny and environment such that barriers to free choice are reduced. The self empowerment approach requires that not only do certain psychological aspects such as fostering self-esteem and the acquisition of lifeskills need to be incorporated into the health education interaction, but also implies that the style of interaction or communication process needs to be taken into account.

### Partnership Model of Communication

It is clear that the empowerment of an individual will not be fostered by didactic and prescriptive messages from the health educator in a manner considered acceptable by advocates of the behaviour change approach. Thus, Downie et al. (1991) state that the “modern” approach to health education must consist of an active learning process which

involves participatory, two-way communication between educator and client. They state that a “partnership” model of communication involves:

“The attendant treating of adults as adults, and of people’s views as important rather than insignificant, which helps to encourage “adult” behaviour and fosters self-esteem” (Downie et al. 1991: 43).

Similarly, Tones (1987) comments that in order to clarify an individual’s beliefs and the values associated with those beliefs, dialogue rather than prescription is required and the perspective of the learner must be shared. He concludes that the health educator must therefore empathize with and respect the client, and must have the inter-personal skills needed to achieve that goal.

Clearly, such comments also have implications for the way in which hospital based nurses should interact with patients. That is, utilizing a self empowerment approach to health education would necessitate the use of such interpersonal skills as active listening, open questioning and reflection.

#### Superiority of the Self Empowerment Model

It is thus obvious that, whilst they are both concerned with an individual’s health choices, the self empowerment model of health education differs in both content and style of interaction in comparison with the behaviour change model. There is evidence to suggest that the self empowerment model is preferable to the latter, not least because of the criticism that the behaviour change approach has attracted (see above). As described above, a basic premise of the self empowerment model is that coercion (such as may be used in a behaviour change approach) is viewed as unethical - instead, the principle of voluntarism is emphasised. In addition, there is no attempt to impose the values of the educator on the client. The employment of the empowerment approach has therefore been advocated on ethical grounds. For instance, French and Adams (1986 ) state:

“self-empowerment approaches to health education are (also) ethically more justifiable than those based on behaviour change” (French and Adams 1986: 73).

It is also apparent from the foregoing that the model is based on theoretical principles derived from the fields of both education and psychology. Tones (u.d.) points out that

self empowerment approaches to health education are based on both a substantial body of psychological theory and also on a wide range of pedagogical and andragogical techniques. The inclusion in the model of the need to clarify beliefs and the values associated with them as a precursor to effective attitude change is based on the work of Fishbein (1980), for example. The influence of psychological theorists is also evident in the related notions of locus of control and self-efficacy, devised by Roter (1966) and Bandura (1977; 1986) respectively. There therefore appears to be some theoretical rationale for the inclusion of the concepts incorporated in the model. There is also some empirical evidence to support its effectiveness in enhancing health. Tones et al. (1990) state that both Friere's (1968) work in developing countries such as Brazil, and Hopson and Scally's (1981 ff) descriptions of lifeskills teaching provide a sound practical basis for self empowerment training. Beattie (1991) also points out that, in relation to what he terms "personal counselling for health", a number of studies are available which report marked benefits for clients. He refers to two sets of examples: the first concerns the success of "anticipatory guidance" programmes in diminishing psychiatric disturbance following bereavement (Murray-Parkes 1979). The second concerns the impact of lifeskills training on adolescents who, as a result, are better able to resist unwanted social pressures to conform to unhealthy behaviours such as smoking and drinking, and are more successful at persevering with healthier lifestyles (Botvin 1984). French and Adams (1986) and Tones (1991) also cite evidence for the effectiveness of a self empowerment approach. For example, Tones refers to Wallston and Wallston's (1978) work on the correlations between internal locus of control and various preventive indices such as smoking reduction and utilization of contraception. He also mentions studies by Langer and Rodin (1976) and (1980) who:

"convincingly demonstrated that providing institutionalized elderly with a relatively minor degree of control over their lives resulted not only in better mental health but also seemed to increase their life expectancy" (Tones 1991: 18).

Within nursing, some support for the success of health education interactions similar to elements of a self empowerment approach is provided by a study by Macleod Clark, Haverty and Kendall (1990). Any conclusions remain tentative due to the small sample size involved. However, they found that nurse interventions that were successful in terms of the patient/ client's smoking cessation were those in which the patient/ client participated fully in the interaction. Successful interactions were characterized by nurses' use of such skills as open questions, listening and positive response to cues as well as clear evidence of the patient/ client's involvement in the planning process and by

a high ratio of patient/ client to nurse talk. These features are clearly linked to the self empowerment model outlined above and thus suggest that it may be effective in promoting health behaviour change. (A further description of this study can be found in Chapter Two).

Thus, whilst many writers have called for the need to develop research and evaluation strategies into the effectiveness of various health education approaches, there is currently some evidence to support the use of self empowerment approaches. Together with its sounder theoretical basis and attention to ethical considerations, it has been widely accepted (at least in principle, if not in practice) as a preferred alternative to the behaviour change approach described above.

### Criticisms of the Self Empowerment Model

The self empowerment model has also been subjected to criticism, particularly by advocates of a more radical approach to health promotion. Inevitably, because the self empowerment approach focuses on individuals, it has also been charged with victim-blaming and a failure to address the wider social and economic determinants of health. Taylor (1990) highlights this as a limitation and argues that it marginalizes the effects that structural inequalities between people can have in limiting the expression of personal power and options for choice. Beattie (1991) also attests that such strategies emphasize helping individuals to learn to cope rather than change their circumstances. A number of counter-arguments serve to weaken this criticism. Firstly, some advocates of what is primarily a self empowerment approach outline the necessity of considering the influence of social, economic and political factors on health choices. Downie et al. (1991) point out that it is necessary for the professional to acquaint him/herself with social and economic barriers to desired action so that the patient can see that his/her position is well understood, and in order to work with the client towards overcoming those barriers. French (1990) also argues that health education should be set within an overview of health determinants and should take account of economic and environmental constraints faced by clients as described above.

Secondly, Tones (1991) defends the model on two grounds. First, that health education operates synergistically with health promotion and it must therefore be complemented by radical health and social policy which tackles oppression. In addition, he argues, these potentially politically unpopular changes can only be implemented by substantial popular pressure, which requires individuals to be empowered. He says:

**“the most significant way to change existing policy is through substantial popular pressure; in order to create such pressure, people need to believe they can influence the course of events and have the skills to do so: they need, in other words, to be empowered” (Tones 1991: 21)**

**Thus, empowerment is seen as a necessary pre-cursor to addressing the wider structural influences on health and in this sense the self empowerment approach cannot be construed as victim-blaming.**

**A further criticism of this approach concerns the fact that the material and methods used are based on value-judgements and are not value-free, since individuals may be influenced and channelled towards socially acceptable behaviours (Taylor 1990). Cribb (1993) also cautions against talk of human values such as participation and empowerment operating as a mask for the exercise of professional power. He suggests that there is a need to question whether “self empowerment” is being used to make individuals change their behaviour and to reflect on whether encouraging participation is used to allow more subtle and effective forms of manipulation. Thus it is important to remain cognisant of the principle of people being free to choose, even if the choice made is “unhealthy” from the nurse’s point of view. This therefore suggests that an awareness on the part of the nurse of his/her own values and expected desired outcomes is necessary, together with a respect for the client’s autonomy. Provided that this is the case, this criticism does not seem sufficient to warrant abandoning this approach altogether.**

**A final criticism is outlined by Beattie (1991). He cites Bernstein and Henderson (1974) who argue that working-class clients may lack access to these strategies for promoting health because they emphasize middle-class values and attributes - that is self-conscious verbalization and self-disclosure and future-orientated life-planning. Similarly, the Radical Therapy Collective (1974 cited in Beattie 1991) argue that such an approach may raise hopes and expectations within a privileged “pastoral” space, which are rapidly confounded in all other aspects of a client’s life. To counteract this criticism, Tones’ (1991) assertion that such forms of health education should be complemented by health promotion action on structural determinants of health inequalities is pertinent. The point also highlights that health education may, either deliberately or inadvertently, raise an individual’s consciousness about the wider determinants of health choices - what Tones et al. (1990) refer to as the “critical consciousness raising” element of health education. Thus, whilst criticisms of this**

model are acknowledged, these can, to a certain extent, be offset, and it is contended here that this remains the model of choice for the nurses.

To summarize, a second model of health education can be identified in the literature which has been termed here the “self empowerment” model. Key features of this approach include the need to foster beliefs about self efficacy, increase self-esteem and the acquisition of various lifeskills. These are regarded as inter-related mechanisms by which empowerment, or a degree of control over one’s health and its determinants, may be effected. There is a concern to promote physical, mental and social facets of health and a broad definition of health is encompassed, not merely the absence of medically defined disease. The implementation of this approach depends for its success on a particular style of communication which emphasizes partnership, participation and dialogue rather than prescription. Whilst it has been subject to some criticism, it represents a more acceptable alternative to behaviour change approaches to health education on the grounds that it is ethically more justifiable and it is derived from more reliable theoretical and empirical work. The model has important implications for the content and style of health education that should be adopted in hospital based nurses’ health education interactions with patients and a summary of recommended features is given at the end of this Chapter.

Other approaches to health education (also described as an approach to health promotion by some authors) identifiable in the literature concern community development or community empowerment approaches. These are not considered here due to the nature of hospital nurses’ current work patterns which preclude any significant involvement in community work of this sort. The extent to which an interaction in, for example, a hospital setting may contribute to action for health within a community via critical consciousness-raising has previously been commented on. More detailed reviews of community development approaches to health education can be found elsewhere (see for example French 1990; Beattie 1991).

### **A Framework for Practice**

In the nursing literature, there have been calls for the profession to adopt an approach which equates with the self empowerment model outlined above. Maglacas (1988) suggests that in order for nurses to fulfill their health promotion role, they will need to develop skills in enabling and empowering people for self-care and self-help. More recently, Tones (1993) has highlighted the centrality of empowerment to the nurse’s health promotion role, by asserting that:

**“if nursing is to take health promotion seriously it must be actively concerned with the empowerment of clients and patients” (Tones 1993: 9).**

**As a result of the above overview of both the possible content of a health education interaction and the different approaches to, or models of health education which are more or less effective, a number of important principles on which health education should be based can be derived. These serve as a useful guide to exploring ward based nurses’ perceptions and practice of health education. Both French (1990) and Downie et al. (1991) have attempted to summarize the key characteristics of effective health education and the list which follows below is based on a combination of these as well as the preceding review given in this Chapter. What can be termed as a “new paradigm” approach to health education as part of broader health promotion includes the following features:**

**A concern with both positive health / well-being and the prevention of disease.**

**The inclusion of information and skills related to physical, mental and social dimensions of health and disease.**

**Information exchange between educator and client about the use and appropriateness of health services.**

**Acknowledgement of, and information and critical consciousness-raising about the social, economic, political and environmental influences on health and health choices.**

**A process of clarifying beliefs and values about health related issues.**

**An emphasis on self empowerment of the client which involves promoting self-esteem and beliefs about self-efficacy as well as enabling the acquisition of lifeskills.**

**Non-coercion, voluntarism and a respect for the client’s autonomy.**

**A participatory, two way dialogue in partnership with the client.**

**When appropriate, education of key policy makers, professionals and those with power, to complement education of individual clients.**

Macleod Clark (1993) has proposed the term “health nursing” be used to encapsulate interactions characterized by the features similar to those described above. She suggests that health nursing is identifiable by partnership and patient involvement in care and decision-making and that the nurse-patient relationship is collaborative, supportive, individualized, negotiated and facilitative. In contrast, “sick nursing” involves:

“patient passivity and dependency, health professional ownership of expertise and decision-making and it focuses on care and cure. The relationships between nurses and patients in this model are therefore inevitably characterized by nursing dominance, a generalized approach to care, prescription, reassurance and didactic information or advice giving” (Macleod Clark 1993: 261).

Clearly, the latter approach bears important similarities to the behaviour change model of health education and adds further weight to the need for nurses to avoid this approach to health education. Macleod Clark’s interpretation also suggests that health education is not confined to a set of particular activities, rather that any interaction or activity undertaken by nurses can have a more or less health enhancing effect. This is similar to Cribb and Dines’ (1993) assertion outlined earlier in relation to health promotion values and activities and has important implications for the measurement of nurses’ health education practice in ward settings, and thus the approach taken in this study.

### **Summary**

To summarize, a review of the literature suggests that there is now some consensus surrounding the meaning of the term health promotion and the place of health education within this broader framework, and this provides a useful background for the study of nurses’ perceptions and practice of health promotion. As French (1990) points out:

“Health promotion is a convenient conceptual tool which enables us to order our understanding of those often diverse elements within society that have the potential to promote health” (French 1990: 8).

The conceptualization of health promotion outlined is based on the premise that both individual and structural elements interconnect to determine health status. This idea can be traced to the public health movement of the 19th century. The activities which health promotion incorporates and the principles and values on which it is based serve to



highlight the way in which nurses' may both conceptualize and develop their role in health promotion. The particular activity adopted by an individual or group of individuals will depend on situational factors and it is intended that these are complementary. Given the occupational setting in which hospital based nurses are located, it is likely that the focus of their health promotion role will be on health education with individuals or groups of individuals. Nevertheless, an awareness of the way in which health education at the level of the individual interconnects with health promotion would benefit such interactions. In addition, hospital based nurses may be in a position to utilize other health promotion activities as appropriate - for example by creating a hospital environment conducive to health. Nurses in a hospital setting may also work collaboratively with other professionals or lay groups within and outside the hospital on issues influencing health.

A review of the literature on health education also outlines what the potential content of a health education intervention might include. Furthermore, different models of health education can be identified in the literature. The behaviour change approach is derived from the medical model of care and is associated with certain characteristics and assumptions. It has been largely discredited due to the simplicity of its assumptions, its dubious ethics and evidence that it is ineffective within its own terms of reference. This approach to health education has been contrasted to a self empowerment model which appears to be conceptually more sophisticated and is supported by some empirical evidence for its effectiveness. The self empowerment model or what has been termed here a new paradigm approach to health education provides information about elements which may inform a health education interaction between a nurse and a patient.

To conclude, the literature reviewed in this Chapter suggests that there is some degree of consensus over the meaning of the terms health education and health promotion. In addition to highlighting the potential role for nurses in health promotion, it also draws attention to key principles and features which may characterize ethically acceptable and effective health education interactions between nurses and patients. This can therefore serve as a framework against which to examine nurses' perceptions and practice of health education and promotion in acute care settings. The extent to which this issue has been addressed by empirical enquiry to date provides the focus for the following Chapter.

## **CHAPTER TWO**

### **HEALTH EDUCATION AND HEALTH PROMOTION IN NURSING PRACTICE: THE LITERATURE**

#### **Introduction**

The previous Chapter highlighted the meanings attributed to health education and health promotion and reviewed evidence to suggest that some interpretations and activities carried out in their name are more useful and theoretically and ethically sound than others. It is evident that the knowledge base underpinning health education and health promotion has developed and advanced considerably over the past two decades. It has been suggested that practice has not uniformly kept pace with this development (Downie et al. 1991). In nursing, the past two decades have also witnessed a new emphasis on the nurse's role as educator and promoter of health. This is outlined in numerous policy documents such as the United Kingdom Central Council for Nursing, Midwifery and Health Visiting's (UKCC's) (1986) Project 2000 nurse education curriculum and the Department of Health's (1989) Strategy for Nursing. However, many of these documents lack clarity as to precisely how this role, and indeed the meaning of health education and health promotion, is to be interpreted. Other recent Government policy documents (for example the Health of the Nation 1992) have also - in theory at least - been influential in determining the shape and the nature of the nurse's role in this area. Based on the theoretical literature, a framework for nurses' health education and promotion practice was proposed in the preceding Chapter. Against this backdrop, it would seem important to clarify the way in which nurses in acute care settings are interpreting their role in health education and health promotion.

The extent to which this question has been addressed by empirical work is the subject of this Chapter. An account of early research in the area, which focuses on patient education and information-giving studies, is presented and some limitations highlighted. More recently, a small number of studies have attempted to examine health education and health promotion in nursing from an expanded perspective. These, together with a number of pertinent studies which focus on other occupational groups involved in the practice of health education and promotion, are also explored. The need for further research in this area is identified and examined.

## **Research Focusing on Patient Education and Information-Giving**

A search of the literature on the health education and health promotion practice of nurses working in hospital settings revealed that the vast majority of research focuses on one particular aspect of this role - that of nurses' involvement in patient education and information-giving. The research focus on these activities can be traced to the late 1960s and early 1970s. In a review of the development of patient education over the last 25 years, Redman (1993) suggests that although the importance of teaching families about such issues as sanitation and care of the sick was recognized by nursing leaders in the last century, it was not until the second half of this century that patient education was "reborn", especially in nursing. Redman suggests that this education was part of an old tradition of all societal institutions, such as the family and religion, and that health might be seen as late in developing its educative function, partly because:

"The most powerful groups in health, namely physicians and hospitals, did not have such a tradition" (Redman 1993: 726).

The rebirth of patient education in the 1960s and 1970s has been attributed to a number of factors. Brandt (1991) for example, points to the following: the new world emphasis on health; the teaching required as a result of the development of the field of rehabilitation after World War II; the increase in chronic illness and disability managed by the patient and families, and because of a change in mood toward authority, including doctors.

## **The Relationship of Patient Education and Information Giving to Health Education and Health Promotion.**

It is widely accepted that the early focus of patient education studies was directed towards increasing the patient's compliance with medically prescribed care. In a review of the literature in this field, Green (1987) states that empirical studies have focused on effective strategies for improving compliance with drug regimes and "health promotion" behaviour changes. Evaluating a representative selection of evaluative studies in patient teaching, Wilson-Barnett and Osborne (1983) also comment that "diabetic", "cardiac" and "drug" teaching predominates in earlier studies which they say demonstrates how highly staff value compliance to treatment. In addition, this demonstrates how research in this field has tended to develop according to particular fields of medical specialization, thus emphasizing its illness orientated nature, as opposed to a broader

focus on health. In her more recent review, Redman (op. cit.) also concludes that education towards compliance with the medical regime has been a clear goal in patient education studies. Redman connects this with the need of each societal institution to develop its educative function to meet its own needs. It therefore seems that, until recently, the preponderance of patient education research is a reflection of health professionals' desire to make the patient conform to the system rather than more altruistic, patient-centred motives which would be more congruent with a broader interpretation of health education.

A review of some of the further characteristics of patient education also make it clear that it derives from a particular ideology which is closely aligned with the behaviour change model of health education described in the preceding Chapter. Levin (1978), in a detailed review, compares patient education to "self-care" and outlines the characteristics of each concept. He argues that some of the characteristics of the former are that: the patient is assigned to the role of learner and sick person under the care of another; goals are initiated in response to a state of disease; the professional regulates the process and outcomes, keeping the control in professional hands; there is an emphasis on assisting the patient to make a good adjustment to hospital, reflecting the expectation of the patient adapting to the system; it is assumed that the patient has little or no previous experience or knowledge, and the focus is on the individual's personal health behaviour and activities without attention to the role of the environment. Luker and Caress (1989) similarly suggest that in the patient teaching situation the supremacy of the nurse in the nurse-patient relationship is evident and the patient is in a dependent role, relying on the nurse for information and skills training. In contrast, Levin describes self-care as follows: having goals which are anticipatory of risk; deriving its goals from the learner's perceived needs and preferences; helping shift the control in health decision-making from the professional to the lay person; relating personal health status to forces in the environment, and using educational methods which include exercises designed to centre health control in the individual. In the light of this, it is possible to suggest that patient education equates closely with the behaviour change model of health education, whereas what Levin describes as self-care is remarkably similar to a self-empowerment approach to health education.

In more recent years, studies into patient education and information-giving in the hospital setting have moved beyond a focus solely concerned with compliance to encompass an emphasis on information designed to reduce stress and thus promote recovery. As Wilson-Barnett and Osborne (1983) point out in their review of patient teaching studies:

“More recent work aims to approach teaching in ways which will alleviate anxiety and help patients’ adjustment to life at home” (Wilson-Barnett and Osborne 1983: 33).

Such studies have frequently involved a process of information-giving to patients and have tended to focus on interventions designed to alleviate surgical stress (Wilson-Barnett and Osborne 1983) or a pre-planned procedure, such as a barium X-ray (Luker and Caress 1989). As Wilson-Barnett (1988) points out, such studies employed standard packages and aimed to provide an accurate account of what to expect, as well as reassurance that patients would not suffer from some of their fantasized harm, and sometimes gave guidance on how to prevent discomfort or complications. These latter studies are more appropriately referred to as those that are concerned with information-giving as opposed to patient education. Although the distinction is often less than clear cut, information-giving can be construed as a simpler in nature and perhaps shorter in duration than patient education. Wilson-Barnett (1988) differentiates the two by suggesting that:

“Definitions of teaching emphasize a change in behaviour, whereas information-giving implies a process or provision, and less concern on how this is received. Education includes providing information and often involves skills training” (Wilson-Barnett 1988: 216).

Thus, more recent work focuses not only on compliance, but also on reducing stress and promoting recovery from illness through information-giving. This has led some writers to claim that information-giving and education can have an empowering function through increasing patient control (this is discussed more fully below). Nevertheless, it is still true to say that the work in these fields is representative of a particular approach to health education and health promotion which is illness-focused and in many ways similar to the behaviour change model outlined in the previous Chapter. It has been recognized that education and information of this nature constitute only one aspect of health education and promotion (e.g. Levin 1978; Wilson-Barnett 1988). Stanton (1982) summarizes it thus:

“In comparison to general health education, which is geared toward health promotion or disease prevention, patient education is usually directed to the individual who already manifests a particular disease process. It focuses on the individual’s current health care needs related to that particular health problem” (Stanton 1982: 14).

Thus, the studies in this area inform only a limited part of the nurse's role in health education and health promotion.

### Limitations of Patient Education and Information Giving Research Studies

In addition, studies of patient education in nursing have utilized research approaches and methods which reflect this limited, behaviour change orientation. The majority of work is characterized by experimental studies that employ a control group in order to evaluate the effects of an educative intervention. The educational intervention provided has traditionally followed a standardized, as opposed to an individualized, format and emphasizes a didactic rather than an interactive approach congruent with the basic characteristics of patient education outlined above. As Wilson-Barnett (1988) points out in a review of the patient teaching and information-giving literature:

“client and patient groups concerned have classically been offered teaching mimicking the format of that for school children.....in the earlier days of the 1960s this type of teaching tended to follow a set pattern devised by the teacher, although individual needs may have been catered for by question and answer sessions” (Wilson-Barnett 1988: 216).

Clearly, this type of education is indicative of a more traditional and limited approach to health education. Similarly, the methods used to evaluate the effect of the intervention reflect this orientation. That is, evaluative patient education studies focus on changes in knowledge and/or self-reported compliance and lifestyle aspects of behaviour. This is identified by Wilson-Barnett and Osborne (op. cit.) in their review of evaluative studies of patient teaching:

“By far the most common way of evaluating teaching is to test knowledge before and after teaching” (Wilson-Barnett and Osborne 1983: 33).

They identify nine studies spanning a period of 11 years which attempted to monitor the effect of teaching on level of knowledge. These range from post-partum patients in Packard and Van Ess' (1969) study who were exposed to either role-delineated teaching or conversational delivery, to 100 patients with ischaemic heart disease in Gregor's (1981) study who were given a booklet and discharge information sheet. In both of these studies significantly higher post-test knowledge scores were achieved by the experimental groups. The authors conclude that the majority of studies reviewed showed some benefits for teaching patients. Similarly, studies on information-giving

to reduce stress have achieved beneficial outcomes. Reviewing seven of these studies, Wilson-Barnett and Osborne (op. cit.) conclude that they usually achieved positive results on at least one or two parameters such as the incidence of complications and recovery rate. Ten years later, Redman (op. cit.) also comments on the research base of the effectiveness of patient education:

“there are now more than 37 reviews or meta-analyses of the accumulated research. Almost without exception, these reviews show patient education to be an effective intervention” (Redman 1993: 726).

Whilst such conclusions are not in dispute, it is clear that effectiveness is defined within the limited terms of reference that patient education offers. That is, benefits are said to have accrued through changes in knowledge levels and often professionally-defined, compliance-related behaviours. Once again, links to the behaviour change model of health education are apparent. The inherent assumption is that changes in knowledge and/or behaviour are beneficial in terms of health outcome for the patient in the same way that the related model of health education assumes the rationality of man and a simplistic chain of reasoning which links the provision of knowledge to subsequent changes in attitudes and health behaviours. The earlier patient education studies do not address aspects of an expanded, new paradigm approach or self empowerment model of health education. That is, they do not evaluate, for example, changes in self-esteem, the acquisition of lifeskills or the critical-consciousness raising function of health education.

In addition, other limitations of the research into patient education and information-giving results in a limited perspective on the development of nurses' role in health education and promotion. Many of the studies (e.g. Johnson et al. 1975; Wilson-Barnett 1978; Thompson et al. 1990) involve educative interventions which are performed either by the researcher(s) themselves or by nurses who have been given specialized training for this purpose, resulting in a lack of data about nurses generally. Furthermore, perhaps due to the experimental design of many of the studies, the work in this area tends to involve one-off, small-scale evaluations of a locally based initiative and there is a lack of research on a wider scale which evaluates this aspect of nursing practice.

## Recent Developments in Patient Education and Information Giving

More recently, there has been a shift in emphasis in the patient education literature. That is, a number of authors have advocated that there is a need to move away from the standardized instructional approaches that have characterized the early work in this field to a more individualized, patient-centred approach. The need for such an approach was recognized as early as 1983 by Simonds in a paper evaluating emerging directions in this field. Reviewing developments in theories of compliance, educational assessments and Leventhal's theory of self-regulation, Simonds concludes that:

“greater importance needs to be given to the individual in health counselling and education and (that) the support for doing so can be found in some of the current developments in theory, research and practice and in the techniques themselves” (Simonds 1983: 175).

In a later paper reviewing some of the literature on patient education in nursing, Wilson-Barnett (1988) highlights the same theme. She suggests that the didactic emphasis of early work is now being questioned and that patient education is shifting toward a more patient centred involvement. As an example, Ozbolt Goodwin's (1979) small scale study involving individualized programmed learning for patients after pulmonary surgery is cited. The researcher devised a booklet to guide rehabilitation according to the individual's ability and recovery rate and evaluation showed significantly positive effects, with these patients suffering a reduced number of infections and periods of hospitalization compared to others in a similar situation. However, it is interesting to note that once again, the researcher provides the intervention and the evaluation measures reflect the pre-occupation in the patient education literature with physical indicators of outcome. Nevertheless, in the light of such studies, Wilson-Barnett suggests that there is a shift in focus in patient teaching from the teacher to the client or patient as the main influence when deciding the content, style and pace of teaching and learning. Similarly, Vaughan (1991), discussing patient education in therapeutic nursing, suggests that it goes well beyond the realms of didactic teaching and the simple imparting of knowledge to another. She argues that teaching should involve sharing and debate about the relevance of the knowledge to a given person at a given point in his or her life and that learning should also occur for the so-called teacher, implying a two-way communication process.

Redman's (1993) review of patient education over the past 25 years, reflects similar conclusions. Outlining developments that remain to be accomplished, she suggests that



individualized patient education reaching goals to the patient's satisfaction and integrated with all care is necessary, as opposed to it being an appendage delivered when time and resources allow. Underscoring the new emphasis on individuality and two-way communication in patient education, Redman states:

“The real goal is the discovery of what fits best the unique experienced needs and aspirations of a particular person, working through shared decision making” (Redman 1993: 728).

Redman also cites Secker-Walker (1990) who, in reviewing the evolving work on adherence to lifestyle change recommendations, notes a focus on: the roles of self-efficacy and self-evaluation, the importance of skills training over and above appropriate knowledge and attitudes, the importance of social support, and recognition of barriers to performance of the behaviour.

Taken together, it seems that the new directions proposed for the field of patient education closely approximate some of the characteristics of the new paradigm approach to health education. That is, there is an emphasis in both on individuality, two-way communication between those involved in the interaction, patient centred decision making, the importance of self-efficacy beliefs and recognition of wider barriers to taking health enhancing action.

Perhaps as a result of this, and the more recent emphasis on teaching patients in order to alleviate anxiety and help adjustment to life at home (Wilson-Barnett and Osborne 1983), it has been suggested that patient education and information-giving are mechanisms by which patients may achieve greater control over their situation, thereby contributing to their empowerment. Tones (1993) for example, links the wealth of research on the successful outcomes of anticipatory guidance prior to surgery and other potentially stressful procedures in acute care settings, to beliefs about control. The indirect link to empowerment is then made explicit through his assertion that central to empowerment:

“is the two-fold task of modifying patients' beliefs about control and providing them with whatever competencies they might need to achieve this goal” (Tones 1993: 9).

Although Tones points out that there is still uncertainty about the precise mechanisms involved, he argues that beliefs about control appear to be central to the effectiveness of

patient education and information-giving, thus implying that these activities can have an empowerment function. Wilson-Barnett and Osborne (1983) propose a similar line of reasoning to explain the success of the interventions that they reviewed. They suggest that one “clue” which emerges to explain the mechanism by which information helps individuals is that if they know what is expected of them and how to do things, through this confidence they can behave in a useful way and feel less dependent and helpless. Although the authors do not specifically identify the empowerment aspect of this process, the link is implicit.

This therefore suggests that the literature on patient education and information-giving may actually be examining health education and health promotion in nursing with a broader perspective than the traditional compliance or behaviour change model as outlined above. It is possible to argue that studies focusing on information-giving and its benefits are in fact shedding light on aspects of the nurse’s role in health education which incorporate elements of a new paradigm approach to health education. However, this argument is weakened by a number of points. Firstly, there is a coercive element to much of this work and Levin’s (1978) earlier point that there is an assumption that the patient will adapt to the system is again pertinent here. Secondly, the extent to which increased control or empowerment of the patient is achieved can only be surmised as it is rarely used as an evaluative measure *per se*. This ties in with both Tones’ and Wilson-Barnett’s comments concerning the uncertainty over the precise mechanism by which success is achieved. Thirdly, the extent to which patient control and self-empowerment is enhanced through information-giving would seem to depend crucially on the way in which the interaction is conducted. That is, if the process of giving information involves a didactic interaction using standardized material and little opportunity for a two-way dialogue tailored to individual patient’s needs, it is unlikely that the patient will feel empowered as a result. The process of information-giving has been less well addressed than the content of such interactions; insofar as it has been commented on, it has tended to involve standardized or generalized content (Wilson-Barnett 1988). And, as Tones (op. cit.) points out, empowerment involves the provision of competencies that lead to a belief that one is in control. It is not always clear that this is an element of interventions included in patient education and information-giving studies.

Thus, despite the recent recommendations that patient education should incorporate some of the characteristics of the self empowerment model of health education and claims that it may contribute to empowerment of patients, there is a lack of research in nursing to evaluate the extent to which these claims are being operationalized in

practice. That is, little is known about the extent to which patient education and information-giving are being practised by nurses in acute care settings, and/or whether these activities are conducted in a manner which is didactic and compliance-focused on the one hand, or whether they are individualized and empowering on the other. Close (1988), reviewing the literature on patient education concludes that studies on the actual teaching done in hospital are scarce and that most of the evidence is of a non-research type. And more recently Redman (1993: 728) has commented that, "there is virtually no description of how frequently it is practised." Clearly then, there is a need to examine through empirical investigation nurses' practice of this element of their health education and promotion role, as well as investigating other facets of this role as outlined in Chapter One. However, the majority of literature gives very little indication about how nurses in acute care settings perceive and practice their role in health education and health promotion in the light of the recent theoretical and conceptual developments in this field.

A small number of recent studies have attempted to address this issue, adopting a broader and more enlightened vision of what health education and promotion represent. These have addressed the issue of models of health education and health promotion operational in practice, largely through examining the perceptions of those involved. A minority of studies have also attempted to move beyond this and document the actual practices of those involved through documentary analysis and non-participant observation. These studies can be divided into those relevant to nursing practice that focus predominantly on occupational groups other than nurses, and those that are concerned with the latter, including those working in acute care settings. The studies, and the implications of their findings for the current study, are reviewed below.

### **Studies Relevant to Nursing Practice Focusing on Health Education and Health Promotion**

Three empirical studies were found which were conducted in the 1980s and which focus specifically on the particular concepts of or orientations to health education and promotion held by various occupational groups involved in its practice. Whilst they involve professionals other than nurses, the methods employed and the findings emanating from this research are relevant to the focus of this study.

A small scale study by Nutbeam (1984) was concerned with the perceptions of health education held by community physicians and health education officers (HEOs) in one District Health Authority. The rationale for the study suggested is that it is important

that these two groups should achieve some measure of consensus over the aims, objectives and methods employed by the health education service. Nutbeam utilized a questionnaire administered to 19 community physicians and 17 HEOs to collect his data, followed by interviews with half the original sample who were randomly selected. Although the exact nature of the questionnaire and interview design are unclear, the author constructed a conceptual model of health education in order to locate the perceptions of the two groups. This model is based on what Nutbeam considers are two key variables with respect to health education - "level of intervention" and "locus of power". According to Nutbeam, preferred level of intervention can be conceptualized as falling between the two extremes of individual centred on the one hand, and society centred on the other. And locus of power is related to health locus of control with polarities that reflect either an "authoritarian" or a "non-authoritarian" approach to health education.

Nutbeam reports that the HEOs broadly speaking favoured society-centred, non-authoritarian approaches to health education. The community physicians' perceptions offered a marked contrast. Nutbeam reported that:

"it was generally felt by the community physicians who were interviewed that health education should be focused on changing individual lifestyle" (Nutbeam 1984: 118).

Furthermore, a slight majority (five) favoured more authoritarian methods of health education, were "much less" troubled by the ethical implications of this and were more concerned than HEOs that there should be some measurable outcome to health education activities.

Whilst this study provides an interesting insight into the perceptions of these two groups, it does suffer from a number of weaknesses. Central to this is the taxonomy constructed by Nutbeam which formed the basis of the questionnaire and the interview protocol. As Rawson and Grigg (1988) point out, it is unclear where this is developed from and there is a lack of detail about any pre-testing of the instruments in order to assess their validity. Details of data collection and the method of analysis employed are vague and the small sample size limits the generalizability of the findings. Nutbeam does, however, attempt to link perceptions to practice, albeit in a rather indirect manner. He states that the "preferred methodology" of those professionals interviewed was explored which served as a control section to test the consistency of earlier answers. Although there was no direct observation of practice, the HEOs reported conflict

between their ideologies of health education and their practice. This was seen to be due to the fact that they were managed by the community physicians interviewed, who, quite clearly held different perceptions. This is suggestive of the importance of investigating both the perceptions and practice of health professionals as well as the influential factors involved in the latter, as preferred ideologies may not be enacted in practice for a variety of reasons.

Whilst Nutbeam's study has limitations, it suggests that a behaviour change type health education model operated in practice and that this was linked to the dominant position of the community physicians. Nutbeam does not offer any explanation for his findings, but it is possible that the different ideologies held were a function of the different types of training of the two groups, with that of the physicians presumably heavily influenced by the medical model of care. It is interesting to speculate that, until recently, hospital nurses' training has also been influenced by a similar clinical model.

A second small-scale survey conducted by Collins (1984) also arose from the need to discover the degree of inter-professional consensus over the concepts of health education held by four different professional groups. The study investigated the concepts held by a sample of GPs, HEOs, Health Visitors and secondary school teachers, both individually and collectively as professional groups. Ten willing members of each profession working in one District Health Authority were interviewed using an in-depth technique. Although Collins makes claims for an inductive approach, an elaborate list of models of health education was comprised *a priori* by the author as a tool with which to analyze the data. Collins does suggest that two major paradigms of health education appeared within the schema ("human-developmental" and "sociopolitical"), but it is difficult to distinguish some of the 19 parameters from one another. For example, amongst the models of health proposed, it is difficult to see how those of "personal co-operation", "personal compliance" and "personal conformity" are appreciably different. This suggests that there may have been problems with the reliability of the data analysis. Collins reports that the research methodology was validated by two independent assessors, each of whom critically analyzed two interview transcripts. As a result she states that the schema was found to be an appropriate tool for analysis and that agreement between assessors' and researcher's analysis of the transcripts "was close". But the study is limited by further details about reliability of the instrument and the analysis process.

Overall, the schema is confusing and, as with Nutbeam's taxonomy, it is not entirely clear where its origins lie. One could argue that a more inductive approach, with

schema developed from the data and compared to broader paradigms of health education and promotion would have been more appropriate.

Despite these difficulties, some interesting findings emerge, some of which are not dissimilar to those elicited by Nutbeam's research. That is, the doctors' group concept of health education was centred around the parameters which Collins describes as "medical", "knowledge transmission", "behavioural/directly regulatory" and "preventive/ propagandist". Such terminology makes it clear that the GPs were interpreting the concept of health education in a manner congruent with the behaviour change model outlined in the previous Chapter, which also shares similarities with what Nutbeam refers to as the "individual/ authoritarian" approach. Their alliance to this model is reinforced by Collins' finding that the GPs made greatest use of the two categories in which compliance or conformity with the health educator's personal aims or views was a major feature.

With regard to the 10 Health Visitors included in the study, there was a closer similarity of score across a number of the health education models, which Collins interprets as reflecting a broader perspective and the ability to draw on a wider range of models in conceptualizing health education. This supports Chapman and Slavin's (1985) assertion that during training, Health Visitors are exposed to a range of health education models. Indeed, Collins herself specifically links the ability of Health Visitors and HEOs to do this with their training:

"The qualitative data support the interpretation that both the breadth of outlook and the low level of unacceptable....parameters of the concept are attributable to the specific training in health education experienced by all health visitors and most of the health education officers in the research sample" (Collins 1984: 86).

The author also comments that the lack of such training emerges from the interpretation of the qualitative data as the source of some of the major difficulties experienced by doctors as health educators, although there is a lack of further detail about this. Given that, until recently, hospital-based nurses have had little or no specialised training in health education, it may be more likely that they hold views which are more congruent with the GPs in this sample than the Health Visitors and the HEOs. Whilst Collins' study does have some relevance to the current study, the reliability and validity of the analysis framework are open to debate and, as Rawson and Grigg (1988) point out, the sample size is such that it is not an adequate basis for generalizing to the whole of the occupations sampled.

Rawson and Grigg's (1988) own study involved a much larger sample of 108 HEOs. Their study was designed to investigate the training and development needs of this group of professionals. Part of the study involved the development of a research instrument designed to elicit occupational philosophies and from this some indication of HEOs' preferred models of health education can be ascertained. The sample of 108 HEOs was obtained by stratified random sampling of all HEOs working in the United Kingdom and thus the findings are more generalizable than those included in either Nutbeam's or Collins' studies. The sample comprised 30 (28.8%) ex-nurses and a control group of "role partners" was also involved, consisting of groups of individuals who worked with the HEOs. A questionnaire was developed based on MODEFI (Models Definition Instrument) constructed by the authors. According to Rawson and Grigg, four health education taxonomies were represented - those of Beattie (1980), Tones (1981), Draper (1983) and Ewles and Simnett (1985). Extensive piloting work helped to ensure the validity of the instrument: this generated a large pool of stimulus items which were then sorted by the authors of the four health education taxonomies represented. Items which were agreed upon were combined into a preliminary questionnaire. Following further pilot work, these statements were "rigorously sifted" to yield a final pool of 25 items. Comparative scores on the health education models generated by the taxonomies could then be constructed. It therefore seems that the MODEFI is a more reliable and valid way of measuring perceptions of health education as it builds on and combines the conceptual development in the field to date and is also made more rigorous by extensive piloting, an aspect which Nutbeam's and Collins' work appear to lack.

Using this method, Rawson and Grigg found that the HEOs gave the highest mean scores to Beattie's (1980) "public agenda setting" model and to Draper's (1983) "about health education" model. The former is described as health education directed at creating changes in the social and political infrastructure of the environment, rather than individual lifestyles. The latter is reported to concern "comparative health" and focuses on the performance of health education. In contrast, the lowest mean score belonged to the "medical" model in Ewles' and Simnett's (1985) classification which is identified by its aim of freedom from medically-defined disease and disability. The authors state that the HEOs most plainly do not see themselves as party to this approach. Thus, the findings bear some similarities to those of Nutbeam and Collins in that HEOs appear to favour a social change or community model, with less focus on individual behaviour change approaches. Unfortunately, the particular views of the ex-nurses in this sample are not distinguished from the rest of the group. Rawson and Grigg also report that compared to the HEOs, the role partners favoured more individualistic, behaviour

change approaches to health education. For example, in relation to Ewles and Simnett's (1985) taxonomy, the role partners showed a definite endorsement of the "behaviour change" model and the "medical" model. However, there is a lack of detail about the models utilized by the nurses in the "role partners" group.

The exact size and composition of the role partners group is also unclear. The authors state that the sample was made up of a wide and disparate spread of occupational groups such as health visitors, teachers, local industrialists, and members of the general public, but give no further details. The authors themselves also state that it is important to caution against interpreting these results too categorically as the role partners sample is too small and biased for drawing general conclusions about wide patterns of health education models. Therefore no conclusions can be drawn about the models utilized by any nurses or Health Visitors in the role partners group.

A detailed account of this extensive study is beyond the scope of this review. However, in their conclusions Rawson and Grigg do point out that the personal work ethic of those nurses and teachers choosing to become an HEO mostly coincides with the prevailing occupational philosophy. It might be inferred from this that at least some nurses interpret health education and promotion in the same manner as HEOs presented above. However, little further detail is provided on this and it may also be true to say that those nurses choosing to become an HEO are not representative of the general population of nurses. In addition, HEOs work in a different way than hospital nurses - Rawson and Grigg describe their current activity as more concerned with being intermediaries rather than direct health education and therefore few comparisons between the two groups can be drawn.

The authors do not attempt to identify any explanations for the preferred models of health education identified by the HEOs and there is no direct attempt to link the HEOs preferred models of health education with their current practice. In fact, Rawson and Grigg highlight that a criticism of the MODEFI instrument was that some of the stimulus items confounded job responsibilities with preferred philosophies in health education. They go on to suggest that this may also be true of the health education models debate more generally - that is, that they conflate models of health education principles with models of health education service delivery. In order to improve the instrument, they suggest that a more comprehensive measure of health education models would reveal additional insights into the occupational philosophies of HEOs. It may also be the case that a more inductive approach, unconstrained by a pre-formulated



instrument, would elicit a more in-depth and valid measure of the way in which health education is understood by a group of professionals.

Whilst the practice of the HEOs is not directly compared to their preferred philosophies, a description of current activities was obtained via the use of work diaries kept by the sample. Some findings appear to indicate that the self-reported practice of the HEOs is congruent with occupational philosophies. For example, Rawson and Grigg report that “policy agenda setting” activities receive a fairly close matching of purpose and practice. However, the study is also limited by a lack of direct observation of practice. The use of work diaries to examine HEOs practice is fraught with the same reliability and validity problems that characterize other self-report measures, such as the accuracy of memory recall. Rawson and Grigg themselves point out that the diary classifications had mixed success and:

“Perhaps most conspicuous by its absence was some means of directly recording facilitating and role building work” (Rawson and Grigg 1988: 63).

Thus, whilst this study was useful in eliciting the preferred models of a representative sample of HEOs using a better validated assessment tool, it nevertheless has a number of limitations. It is also true to say that few conclusions regarding the perceptions of hospital based nurses can be drawn from this study due to the differing backgrounds, experiences and ways of working of the two groups.

As a whole, these studies make an important contribution to understanding professionals’ interpretations of health education and health promotion from a broader and more enlightened perspective than the nursing research studies focusing on patient education and information-giving alone. However, they do suffer from a number of limitations, as outlined above. The findings from these studies indicate that the preferred models of health education adopted by HEOs differ from the more prescriptive, medical-model derived preferences of the medical profession. Although there is no empirical data on hospital nurses’ perceptions in these studies, it can be argued, that if training and experiences are influential, then their perceptions are more likely to be similar to the physicians rather than the HEOs.

## **Research into Health Education and Health Promotion in Nursing**

A small number of studies have focused specifically on either the perceptions and/or the practice of health education and promotion by nurses, including those of hospital based nurses. These are reviewed below.

### **Studies Using Self Report Measures**

Several recent studies have examined this issue utilizing a deductive approach, incorporating questionnaires in order to elicit data. Bradford and Winn's (1992) survey of practice nurses working within one District Health Authority was prompted by the NHS GP contracts introduced in 1990. The authors state that the workload generated by these contracts is centred around health promoting activities, many of which may be delegated to the practice nurse. The research focused on an examination of the nature of the work carried out by practice nurses and "their views about health promotion" and provides some insight into this largely unexplored area. A questionnaire was sent to all practice nurses in one Health District (n=103) requesting information about the nature of health promotion work currently undertaken. Views about health promotion were ascertained by asking respondents to rank in order of preference five models of promoting health, to select the model which best described their working practice and to use Likert response scales to agree or disagree with four short statements about the nature of health promotion. The models selected for inclusion were based on Ewles' and Simnett's (1992) classification into medical, client-directed, educational, behaviour change and social change models. Whilst these can be taken as representative of a number of different approaches to health promotion, this classification suffers from a number of weaknesses. Firstly, only the latter could truly be regarded as operating at the level of health promotion - the others are more appropriately classified as health education, occurring at the level of the individual. Secondly, the central importance of empowerment is lost as it is subsumed under the "client-centred" approach. Thirdly, as Bradford and Winn point out, there is overlap between the models; it is unclear how the medical and behaviour change on the one hand, and the educational and client centred approach on the other, would actually differ in practice.

From a response rate of 63% (n=65), a pattern of current activities of practice nurses was compiled. The authors state that despite the recent emphasis on the performance of health promotion duties, much of their time is devoted to treatment-orientated services, with high levels of activity reported for clinical tasks such as collecting samples (83% n=54) and suture removal (85% n=55). Nevertheless, "health promotion" duties (as

specified in the NHS GP contracts) were being carried out by the majority of respondents - for example, 88% (n=57) reported involvement in "health promotion" clinics. Whether or not such activities actually constitute health promotion is open to debate and may depend on both the content and style of the interaction occurring at a clinic or screening contact. Unfortunately, there is no data collected on the actual practice of this sample of nurses and therefore no conclusions can be drawn. However, the authors themselves do suggest that the clinics could be seen as disease management rather than primary health promotion and that their position as the latter is debatable.

The practice nurses' views about health promotion were mixed, but are suggestive of an underlying preference and practice of the more traditional, medical model derived approaches. For instance, 64% (n=42) of respondents regarded the social change model as their least preferred model and only one nurse (2%) reported using it in practice. In contrast, 37% (n=24) reported using the medical model of health education in practice and 9% (n=6) ranked it as highest preference. Similarly, the behaviour change model was ranked as highest or second highest by 50% (n=33) of the practice nurses, whilst the client-directed approach was viewed as most preferable by only 13% (n=8) of respondents.

With regard to the Likert scale responses to the four health promotion statements, Bradford and Winn suggest that three of the statements were linked to the most radical, social change model, whilst the remaining statement was reflective of the medical and behaviour change models. The authors state that overall, respondents were more in agreement with the radical statements of health promotion and more than half disagreed with the most conservative statement. On the other hand, they suggest that because only 55% (n=36) agreed with a statement about working together with others to change health policy, this implies that whilst practice nurses may recognize a socio-political aspect to health promotion, the concept appears to be far removed from their working practice.

It is also questionable whether the statements are an accurate representation of the social change model. For example, the statement with which 88% (n=57) agreed: "If I spend time educating people about their health they in turn will educate others" conveys a somewhat inaccurate understanding of the basic tenets of a social change model. Similarly, the link between the statement "Patients are not concerned with issues beyond their own health status" and the behaviour change or medical model lacks clarity and therefore the validity of this aspect of the questionnaire is debatable.

Therefore, a more inductive approach to eliciting nurses' views may have been a more valid and discriminatory method of data collection.

Bradford and Winn conclude that the prominence of the use of the medical model and the types of clinics undertaken suggests that health promotion services are at present largely prescriptive and centred on the individual rather than providing a wider and social emphasis. Although any speculations about explanations for this finding are not proposed, it is interesting that a medical model approach to health education was also preferred by the GPs in Nutbeam's (1984) and Collins' (1984) research reviewed above. Given that practice nurses, like the HEOs in Nutbeam's study, are the employees of doctors, perhaps it is not surprising that they adopt a similar approach to health education. Bradford and Winn also suggest that the attitudes of practice nurses towards health promotion are "key determinants" of the way in which health promotion services are provided in general practice. However, this link remains only tenuous and any conclusions from this study are limited due to lack of observation of practice and the use of self-report data only, as well as some problems with the validity of the questionnaire, as described above.

A second study which aimed to explore nurses' attitudes to health promotion using self report measures was conducted by McBride (1993), and involved nurses working in acute care settings. Again, a survey design was employed and a questionnaire utilized to elicit the data. Although McBride claims she was interested in "health promotion", an examination of the items included in the questionnaire indicates that the term is used rather inappropriately to refer predominantly to items which are really concerned with nurses' views about a rather prescriptive approach to advising patients about aspects of their lifestyle contributing to ill-health. For example, nurses were asked to indicate the extent to which they agreed with the statement : "Hospital nurses should interfere with peoples' lives by telling them to stop smoking, lose weight or take more exercise" and this is subsequently referred to as "health promoting activity". Therefore the study's findings are limited primarily to nurses' perceptions about the lifestyle advice element of their health education and health promotion role. Nevertheless, a few findings are relevant to the focus of this study.

A postal questionnaire was distributed to 296 qualified nurses working on adult acute wards within one large teaching hospital and a random selection of 50 nurses from another District Health Authority. The questionnaire comprised both multiple choice and Likert scale items. A response rate of 76% (n=225) was achieved, therefore representing a reasonably large scale survey of acute-based nurses. Whilst the focus of

the questionnaire concerned lifestyle advice, three items also addressed nurses' views about a wider role for themselves in what would be appropriately considered "health promotion". Thus, nurses were asked whether they felt they should be health advocates, insisting that health promotion is put on the political agenda. McBride reports that 95.5% (n=215) of the sample agreed with this statement. Furthermore, McBride reports that 89.5% (n=201) of the sample felt that they should take a leading role in the prevention of disease in their local community. Whilst these results are encouraging and appear to suggest that nurses perceive a role for themselves which is broader than one-to-one lifestyle advice, the nature of the data collection should be borne in mind. That is, it is possible that the high level of agreement on these items is a function of the Likert style format of the questionnaire, with nurses unlikely to disagree with these sort of favourable statements.

Other items address under what circumstances nurses would ask patients about aspects of their lifestyle mentioned above, ranging from "routinely" to, for example, when a patient has a smoking-related disease. The results suggest that the majority of nurses frequently ask patients about these issues. For example, 90.2% (n=202) reported that they routinely ask patients about smoking. However, these items assume that asking patients about their lifestyle habits equates with health education practice by the nurse, when clearly, it is what the nurse does with the information gained as a result that is the key issue. Respondents were also asked what they were likely to do if they identify a patient with a lifestyle problem in relation to either smoking, alcohol, exercise or diet. With respect to each issue, the most common response was to offer either literature/leaflets or simple advice. For instance, 83.1% (n=187) said that they would offer simple advice about exercise and 91.5% (n=205) reported that they would offer literature or leaflets to a patient requiring advice on stopping smoking.

However, despite the popularity of the simple advice and literature/leaflets options, the data illustrates little about how such advice would be given and it is unclear whether nurses favour an empowerment approach or one which more closely resembles a behaviour change, medical-model derived intervention. In addition, in keeping with the assumptions underlying the design of the questionnaire, choices of action which emphasize a less individualistic approach are not given. For example, the response choices do not include raising consciousness about the wider constraints to health promoting behaviour or working with other professionals towards policies which promote health.

Some data that indirectly shed light on the way in which nurses may be interpreting their health education role comes from another item included in the questionnaire. McBride reports that when asked if health education is guilt-inducing and victim-blaming, 81.1% (n=182) of the hospital nurses felt that this was not the case. This may suggest that the nurses are giving education and advice in such a manner as to avoid this, or alternatively, it may reflect a lack of insight and reflection on their practice. Interestingly, an overwhelming majority of the nurses (84.3% n=190) agreed with the statement, "Hospital nurses should interfere with people's lives by telling them to stop smoking, lose weight or take more exercise" suggesting that a prescriptive approach is acceptable to many.

Thus, McBride's study provides mixed and rather inconclusive data on nurses' perceptions about health education and promotion in acute care settings. The research is limited by a deductive approach and the assumption that health promotion consists largely of lifestyle advice. The data therefore reveal little about nurses' perceptions and practice of other aspects of their role in health education and promotion. In addition, as with Bradford and Winn's (1992) study, the findings are confined to self-report data only with no observation of practice. Therefore the validity of the data remains open to question and the relationship between nurses' perceptions and their practice remains unexplored.

One study which did attempt to move beyond the use of questionnaire data only and incorporate additional indirect methods of capturing practice, as well as a reportedly more inductive methodology, was carried out by Davis in 1992. This study focused on rehabilitation nurses and aimed to explore their understanding of health education and health promotion and their role within it, with a view to developing a model of health promotion on which practice could be based. A combination of questionnaires, content analysis of care plans and group interviews were conducted. Both qualitative and quantitative data were collected from the questionnaires. Of particular interest were the open-ended questions used to elicit the nurses' understanding of the concepts of health education and health promotion. The questionnaire also contained a list of topics which respondents were asked to classify as either health education or health promotion, both of these or neither. These included topics such as smoking advice, giving psychological support to patients and to relatives and encouraging patients to be involved in policy making. Davis states that the formulation of the questionnaire was based on a Delphi survey of three experienced rehabilitation nurses, followed by individual taped interviews with these personnel and validation from the literature. However, it remains unclear as to why some items were specifically included, such as

instruction in activities of daily living and monitoring blood glucose. The content analysis of care plans was conducted to determine whether “the nurses used health promotion related words when writing clients’ care plans” (p31). The researcher states that whether they did or not allows inferences to be made regarding both the client and the nurse’s role in health education and health promotion. A list of 15 health promotion words were identified from the literature, the researcher’s experience and the process validated by a Master’s prepared expert in health promotion. The words were classified as either client or nurse centred or those that could be either. Davis states that the former were those that implied the client was seen as an individual who was being empowered to make his/ her own decisions and the latter were those that implied the nurse made decisions for the client. However, the validity of this approach is questionable as it could be argued that the nurse or client-centredness of the words are context- dependant. For example, “advocate” (classified as a client centered word) and “promote” (classified as a nurse centered word) may more or less approximate an empowering approach depending on the context in which they are recorded. This method also assumes that there is congruency between what nurses record on care plans and what they actually practice, which may be inaccurate for a number of reasons. The group interviews were undertaken to allow nurses to discuss the issues together and to come to some agreement regarding health education, health promotion and the nurse’s role. Davis reports that group rather than individual interviews were used to create a more informal conversational style, although it is debatable whether this was actually achieved in view of the fact that each of the three interviews actually comprised only two nurses. The interviews were semi-structured and nurses were asked specifically about their role in health education and promotion, and improvements and constraints to the role.

The study involved a sample of registered nurses working in two neuro-rehabilitation centres. As Davis points out, this meant:

“the study was limited to brain-injured clients as this was the researcher’s area of expertise” (Davis 1992: 26).

The study was also limited by the small size of the sample - only 18 nurses completed questionnaires out of a possible 33, representing response rates of “around 70% from one of the centres and 40% from the other”. No further details are given in order that the possibility of sampling bias can be excluded. In addition the group interviews involved only six nurses. Davis states that 39 care plans from both centres were examined, although again exact details of the sampling are not given.

The qualitative data from the questionnaire were analyzed by identifying categories and comparing responses. The findings indicate that the nurses' understanding of the concepts of health education and health promotion were limited and rather confused. Davis reports that ten (55%) of the nurses described health education as a teaching activity and all of them described it as an information-giving activity. However, the data presented indicate that there was a lack of recognition of some of the concepts involved in a new paradigm approach to health education, such as the need to foster control and esteem or offer individualized advice as part of this process of teaching and information-giving. Davis comments on the one hand that the nurses expressed difficulty distinguishing between health education and health promotion but, conversely, states that clear distinctions were evident with health promotion being identified as being concerned with environmental and political issues. However, from the data presented, Davis' conclusion would appear inaccurate. Comments about health promotion included the following:

*"the same or similar as health education"*

*"same as health education but performed differently....using persuasion and encouragement to arouse public interest and awareness."*

*"publicity, encouragement and general health living issues....putting all the information over to the general public."*

Such comments do little to substantiate Davis' conclusions and suggest that the nurses' had a limited understanding of health promotion and its distinction from health education. This is further reinforced by data from other items included in the questionnaire. Responses to the item requiring nurses to classify 26 activities as either health education, health promotion, neither or both demonstrates a lack of ability to discriminate between the two. Davis reports that the majority of activities were classified as both health education and health promotion. This may have been the result of the lack of clarity of many of the activities, such as "diet management" and "promoting the avoidance of toxic substances". However, nurses' lack of clarity over the meaning of the terms is also evident. For example, 39% (n=7) of the sample classified "monitoring blood glucose" as health education, 33% as both health education and health promotion, 22% (n=4) as neither, and one nurse as health promotion. One of the items that is clearer with regard to its classification as health promotion- "policy making" - also yielded mixed findings. Fifty four per cent (n=9) of the sample regarded this as neither health education or health promotion, 22% (n=4)



classified it as both, 11% (n=2) as health education and 11% (n=2) as health promotion. This suggests that many of the nurses were not cognisant of the policy level at which health promotion operates.

Analysis of the qualitative data from the open-ended items in the questionnaire also revealed mixed findings regarding the role of the client or patient in health education and promotion. Davis states that 55% (n=10) of the nurses identified the patient's role as passive whereas 44% (n=8) regarded it as mainly active. Findings from the content analysis of care plans were also mixed. Whilst Davis concludes from this aspect of data analysis that:

“The language used in the care plans....implied that the majority of clients were not recognized as co-managers of their rehabilitation programmes” (Davis 1992: 76).

she nevertheless states that the language did not imply a totally passive role. She reports that words such as encourage, negotiate and establish indicate an attempt on the nurses' part to involve clients. However, as previously mentioned, the reliability and validity of this aspect of data collection is limited due to the ambiguities inherent in classifying isolated words as either client or nurse-centred.

During the “group” interviews nurses were asked about their role in health education and health promotion. Unsurprisingly, their responses are closely linked to their perceptions about the concepts themselves, although Davis does not comment on this. Thus, the nurse's role was identified as primarily one of teaching and information-giving, reflected in such comments as :

*“disseminate information”*

*“advise patients and families”*

*“teaching patients to adapt”*

Further, Davis reports that the nurses identified their role in health promotion as generally covering the same areas as health education and that the nurses expressed difficulties in identifying differences between the two. Thus, this data reinforces the conclusion that nurses' perceptions were rather limited and confused and it seems that ideas about their role are necessarily limited by their understanding of the concepts.

It is possible that Davis' use of open-ended questions to elicit qualitative data about perceptions yielded a more accurate account of nurses' understandings than the more structured approaches adopted by both Bradford and Winn (1992) and McBride (1993), both of whose findings were more favourable. However, the findings are restricted to a small sample of nurses working within a specialized area of hospital nursing. In addition, Davis' study is also limited by a lack of observation of nurses' practice in order to understand how nurses' role in this area is developing. As Davis herself points out, none of the methods allowed for the nurses to be observed in practice, to identify whether practice substantiated their responses. Observation of nurses' practice may also have served to illuminate further the link between perceptions and practice suggested by the researcher in her conclusion to the study:

“nurses cannot adopt a philosophy of health promotion if they do not understand its principles, and its relationship to health education” (Davis 1992: 83).

In the light of this, an empirical exploration of this link, utilizing both self-report and observational methods, would seem desirable.

Williams (1987) also investigated the development of health promotion in nursing utilizing a somewhat different self-report measure - a literature review. Using this method, the study was concerned with describing, evaluating and explaining assumptions about health promotion in nursing in the United States. Williams aimed to determine the model of health promotion which was dominant in the literature, and to examine the implications of this for the health of the population and the social responsibility of the profession. Two contrasting models of health promotion are constructed by the author as a basis for examining the literature. An “atomistic” model is referred to as being derived from classical liberal theory and characterized by an emphasis on behaviours as free, rational, self-interested choices. Health is viewed as determined largely by lifestyles for which individuals have responsibility and therefore interventions are concerned with the provision of information to enable rational choices about healthy behaviours. Thus, the similarities with the behaviour change approach described in Chapter One are self evident. In contrast, the “totalistic” model outlined by Williams more closely equates with what is now commonly known as health promotion. That is, this model assumes that health is socially derived and cannot be divorced from the environment and one's position in the social structure. Thus, Williams states that this implies that:

**“society should be required both to create health - promoting environments and to empower all people to participate in the creation of that environment”  
(Williams 1987: 142)**

**Williams use of these two models as a framework for examining the literature could be criticized on the grounds that they represent a rather simplistic polarity of approach. Whilst she refers to the need to empower people, she does not, for example, outline an empowerment approach to individual education. Instead there is a tendency to conceptualize individual and collective approaches as two opposite extremes.**

**The method employed consisted of a review of American nursing literature on “health promotion” published between 1980 and 1984, comprising 70 articles for analysis. Williams devised content analytic categories to examine each article: stated definitions of health education/ promotion; statements about health determination; statements about responsibility for health and any interventions described. The study found that the atomistic model was dominant. One hundred and thirty one content items related to statements about health determination, responsibility for health and interventions were yielded. Of these, 92% (n=121) were classed as atomistically orientated, and only five articles contained assumptions compatible with a totalistic model of health promotion. Williams states that the atomistic model was taken as given, with little conscious discussion or rationale for it proposed. She argues that this lack of explicit attention to the interaction of lifestyles with wider social issues of class, race and gender means that nurses’ health promotion activities are likely to perpetuate the status quo. That is, only socially advantaged groups are likely to be able to make free and healthy choices, thus resulting in a continuation of the unequal distribution of health, which health promotion aims to eradicate.**

**Williams also advocates a re-orientation within nursing away from a focus on the individual towards more collective patterns of working which would enable the structural influences on health to be tackled. However, this is related to her polarized models of health promotion and the lack of conceptualization of how an empowerment approach to health education at the level of the individual may contribute to an individual's health and health promotion on a wider scale. In addition, the relationship between perceptions of health promotion as outlined in the literature reviewed and nurses’ practice is assumed, and it would seem important to examine the relationship between perceptions and practice through more detailed empirical enquiry.**

### Studies Incorporating Observation and Recording of Nurses' Practice

A small number of studies have incorporated observation as a research method in an attempt to explore aspects of nurses' health education and promotion practice. A study by Kendall (1991) aimed to explore the extent and nature of client participation in health visiting interactions within the framework of the Health Visiting Process. Whilst the study focused on client participation as opposed to health education or promotion *per se*, as the preceding Chapters make clear, promoting client participation in an interaction forms an integral part of the nurse's role in health education and promotion. As Kendall herself points out, the issue of client participation is perceived to be of particular relevance to the health visiting profession where health promotion is regarded as central to the work. Qualitative and quantitative approaches were combined in order to address the aim of the study. Semi-structured interviews were conducted with health visitors and clients in order to ascertain their perceptions of various facets of the visits and to explore health visitors' understandings of relevant concepts such as enabling and participation. In addition, the study is enhanced by direct observation of practice involving the tape-recording and non-participant observation of health visitor-client interactions. Sixteen health visitors from two health authorities took part in the study and a total of 62 interactions were analyzed. Data on the health visitors' understanding of the concepts of enabling and participation were analyzed using a qualitative approach as it was considered important to explore in some depth what they understood by concepts underlying the Health Visiting Process. The tape-recorded interactions were also analyzed qualitatively, using a modified approach to conversational analysis in order to ascertain the nature and extent of client participation in the interaction.

A detailed description of the findings from this study is beyond the scope of this literature review, and can be found elsewhere (Kendall (1991)). Of relevance to the current study was the finding that although the concepts of enabling and participation were viewed positively, there was an overall lack of evidence that these were being operationalized in the context of the health visitor-client interaction. Enabling was understood by the Health Visitors as being concerned with self-help, decision-making and the realization of human potential. However, in spite of the apparent sophistication and client-centred nature of their responses, Kendall points out that underlying this was the notion of client dependency on the health visitor to achieve this, as evidenced through the use of words such as the health visitor "gives", "allows" and "helps". She also states that:

“Interestingly, nobody chose to describe enabling as a process of “empowerment”. Indeed, there was very little sense of relinquishing control completely or recognition of the client as expert” (Kendall 1991: 197).

Kendall also suggests that this was further illustrated by the way in which the health visitors described participation. That is, whilst generally receptive to the idea, they perceived this as an ideological rather than a reality based concept. In addition, it was perceived as relevant to selected groups of clients only which Kendall suggests hints at a form of social prejudice which allows the health visitor to retain control over certain client groups.

Coupled with the fact that information on how the concepts were put into practice and the skills required to do this was not forthcoming from the health visitors, this suggests a rather superficial acceptance and understanding of these central concepts of health promotion. Indeed, the underlying notion of client dependency and health visitor control is indicative of the existence of an ideology in operation which is rather different than a self empowerment model and which more closely approximates that of the medical model, behaviour change approach outlined in the preceding Chapter. Kendall’s analysis of the recorded interactions appears to reinforce this idea. It was found that the predominant feature of the interactions was the overall lack of evidence of client participation in terms of clients being involved in setting their own agenda, contributing their perspective or experience of a topic, setting their own objectives or goals or being actively involved in decision-making. This was largely explained by the approach of the health visitors to the encounter who controlled the interactions in terms of setting the agenda, collecting and selecting information, giving advice and closing the encounter. Unsurprisingly, analysis of the semi-structured interviews conducted following the visits demonstrated that incongruent perceptions existed between health visitors and clients concerning such aspects as the purpose of the visit and the subsequent plan of action. Thus, although the health visitors were apparently favourable towards the concept of participation, this was not being enacted in practice. This therefore highlights the need for direct observation of practice in addition to self-report data, as the latter may be an inaccurate account of the reality of practice. This may explain the favourable findings of studies such as Bradford and Winn (1992) and McBride (1993).

Whilst Kendall’s study provides important information about the extent to which participation is operationalized in practice, to date there has been a lack of empirical work which examines this issue in acute care settings, and the applicability of Kendall’s

findings to hospital nurses' work is uncertain. However, given the longer tradition of health education and promotion in health visiting, it is likely that hospital nurses' perceptions and practice are less well developed. In addition, the focus of Kendall's study was on client participation as opposed to a broader focus on the development of nurses' health education and promotion role more generally.

A second study which employed direct recording of nurses' practice, and which focused on the smoking cessation advice aspect of health education, was conducted by Macleod Clark, Haverty and Kendall in 1990. The aim of the study was to explore the content and process of nurses' health education interventions and to assess their effectiveness in terms of changes in clients' or patients' smoking behaviours. A self-selected sample of 20 nurses, including ward sisters, health visitors and midwives, were exposed to a two day training programme. Following this, health education interventions were tape-recorded by 16 of the participants, giving a total of 68 interactions for analysis. The findings from the study indicate that many of the nurses continued to use a prescriptive approach to advice-giving in these interactions and there was little evidence of the ability to involve clients in the process of planning a strategy for change, despite input on the skills required for this during the study days. Macleod Clark et al. reported that whilst one or two clients participated to some extent in working out a cessation strategy:

“In general, though, the nurses tended to fall back on prescriptive advice, telling the client what was “best”, not focusing on the client's needs, or allowing the client to think about what would work best for them” (Macleod Clark et al. 1990: 25).

However, some degree of success was achieved (for example, 17% (n=7) of the sample continued to abstain from smoking at a one year follow up), and, whilst acknowledging the small sample size, the authors make a tentative link between the process of the intervention and its outcome (as described in Chapter One). That is, there appeared to be some relationship between the use of specific skills such as open questioning and listening and successful outcomes in terms of smoking cessation. Successful interventions were also characterized by patient or client participation in the planning process and a high ratio of patient/client talk to health professional talk. Whilst this is encouraging, there is some evidence to suggest that the hospital nurses in the sample (n=3) were least able to use this approach. For example, the study found that the hospital nurses were least able to make a detailed assessment of the clients as they had often only just met them, whereas the health visitors and midwives often knew

their clients quite well. This suggests that the degree of continuity in the health professional and client/ patient relationship may be influential in allowing nurses to develop this type of health education approach. In addition, the authors report that the positive influences of the interventions were particularly apparent in the health visitors' and the midwives' interactions. Although little detail is provided, by implication this suggests that the hospital nurses were least able to involve clients in the interventions.

Macleod Clark et al. suggest that the health promoting approach to care advocated in the training programme (which approximates the self-empowerment approach described earlier) differs radically from that which nurses more generally are trained to adopt. They suggest that such a shift in approach requires radical re-thinking of the principles, philosophy and practice of nursing and is unlikely to take place quickly in a profession where "prescription" and the medical model have been accepted for decades. Consequently, the authors suggest that continuous education and updating in the principles and practice of health promotion for trained health professionals is called for.

This study therefore also provides evidence that nurses are operating with a prescriptive approach to health education in practice and that the historical influence of the medical model is instrumental in this. The conclusions which can be drawn from the study, as the authors point out, are limited due to the small sample size. It would therefore seem beneficial to examine nurses' health education perceptions and practice with a broader perspective, not only by using a larger sample of nurses who have not received specialized input, but also including an examination of whether other facets of the role are being interpreted in a similar manner.

A study which attempted to do this, and which provides the only example of a large scale study involving an examination of the health promotion practice of nurses was conducted by Gott and O'Brien in 1990. This study is therefore reviewed in some detail here. The research was directed towards understanding the relationships between the health promotion roles played by nurses and the context in which those roles are undertaken. Gott and O'Brien argue that these relationships are important in understanding how it is that particular orientations to and practices in health promotion both emerge and are sustained. This assumption means that the study examines the issue of health promotion in nursing from a broad, sociological perspective and the findings from the study are continually linked to nurses' roles and relationships with others within the health care sector and within society more generally. This means that there is often a lack of specific empirical data to support the authors' conclusions and as such could be regarded as one of the study's few limitations (see below). The research

adopted a qualitative approach and employed both interviews and observation of nursing behaviour in its context. The authors state that the methodological approach adopted is based on the principles of analytical induction which enables the researcher to engage with the data in “critical case analyses”. The critical cases used to organize the data refer to the working situations of nursing, such as “health promotion at school and work” and “information for the hospital”. Thus, a variety of different locations and settings are included in the study.

Gott and O’Brien selected cardiac rehabilitation work as the focus for their study as they suggest that this is the area where greatest progress in health promotion is considered to have been made. However, they also suggest that the issues raised by the research are not exclusive to this area of practice, but are applicable to the field of nursing more generally. Again, this rests on the assumption that it is the context within which nursing generally finds itself that determines health promotion practices rather than any situation-specific factors. It is possible to suggest that health promotion within cardiac rehabilitation work may differ from other areas of nursing practice - for example, it is particularly amenable to a risk-factor lifestyle approach due to the aetiology of the major cardiac diseases and necessarily involves health education at a secondary or tertiary, as opposed to a primary prevention level.

The sample comprised a variety of different groups of nurses, including occupational health nurses, school nurses, health visitors, district nurses and practice nurses as well as those working in hospital settings. Data were collected in 27 settings in 5 different Health Authorities, including 5 hospitals, making it a comparatively large scale study with respect to research that has been conducted in health promotion and nursing to date. Sixty five nurses were interviewed in total, either individually or in groups utilizing a semi-structured schedule which aimed to explore themes related to ideologies and practices of health promotion and to unpack attitudes and processes in order to display their relationships to the research subjects’ situations. The observational guidelines that were developed also reflected this aim and were concerned with a broad description of nurses’ activities and the context of those activities. Whilst the observation guidelines include attention to the educational activities of the nurse, the data are limited to non-participant description and therefore lack the detail that could be provided by audio-recording of nurse-patient interactions. There is also a lack of detail about the manner in which the observation was carried out and recorded, other than the fact that it was designed to fit with the normal pattern of nursing work. Observation was conducted in the variety of settings in which the various groups of nurses worked. Of particular relevance to the focus of this study is the fact that this included three



different hospital locations, comprising two coronary care units (CCUs) and one cardiology ward.

The findings from the interviews suggest that the nurses' perceptions about health promotion were poorly developed and linked to an individualistic, lifestyle intervention approach. Gott and O'Brien report that, for all groups of nurses, lifestyle interventions were seen to constitute the effective vehicle for their work and that this was reduced to merely getting the information across combined with a supportive stance to the recipient's situation. When asked about the distinction between health promotion, health education and prevention, there was a general confusion about what health promotion actually represents and an overwhelming tendency to see these elements as one and the same thing. In addition, there was limited understanding of some of the central tenets of health promotion philosophy as outlined in the Ottawa Charter (WHO 1986b). For example, in response to a question about collaborative and team working, the study found that although respondents generally felt this was a good thing, they were unable to elaborate on what this should or could involve. Gott and O'Brien report that they tended to engage with the concept of multi-sectoral work with reference to their own sector (i.e. the health service) and to their referral function. Similarly, the concept of participation was given little importance by the nurses, with very little weight given to people's own agenda except insofar as these expressed specific "problems" which the nurse could address. And the notion that people might meaningfully participate, individually and collectively, in the design, planning, implementation and evaluation of health services operated by nurses was a long way down respondents' list of priorities. From the interview data the authors conclude that:

"The major strategies which our respondents proposed for achieving behaviour change within individuals revolved around the attempt to foster different attitudes to specific risk-factor dimensions. Little understanding of the nature of "collaboration", "teamwork", "participation" or of strategies for community development and control over health services was in evidence" (Gott and O'Brien 1990: 112).

Observation of nurses' activities revealed similar findings. Gott and O'Brien report that the major themes to emerge concern the extent to which health promotion is viewed as a "point-of-delivery" issue involving massive attention to risk-factor intervention directed at behaviour change. A review of the findings from all of the settings in which observation occurred is beyond the scope of this literature review and the researchers' also report that certain "key" encounters appeared as cross-situational elements of

nursing practice. Whilst interview data from the hospital nurses is not reported separately from the other groups, an interesting account of the activities observed in this particular setting is provided. The researchers report that the wards functioned on a task-orientated basis and that activities revolved around patient record sheets which were divided into problem areas such as hygiene and mobility. They suggest that these were vehicles for fulfilling particular tasks required by the ward's mode of operation and functioned to constrain nurses' interactions with their patients because they served to organize the nurse's understanding and value of their tasks. Gott and O'Brien suggest that this was tied to the nature of the CCU as a social system in that patients entered and left within a period of 48 hours and therefore there was a great need to extract information which could be relayed to the patient's next ward. This is also linked to the finding that nurses had difficulty in eliciting the patient's perspective. That is, the researchers suggest that this is unrealistic (i) in the period immediately following a myocardial infarction, (ii) when the patient is unfamiliar with the hospital and the system and (iii) due to the rapid turnover of patients in the unit. Whilst acknowledging these difficulties, it could be argued that these findings are a function of the setting chosen for observation - i.e. the special nature of cardiology and CCUs - and whether they are applicable to other acute ward settings is not established. Gott and O'Brien also describe the admission procedure on the cardiology ward as a vehicle for collecting information for the institution rather than the patients themselves, in which patient information is standardized into manageable patterns for use by other health service personnel. The researchers use this finding as evidence of their conclusion that people's own requirements are over-shadowed by medical and quasi-medical needs and this constrains the development of health promotion. There is however, a lack of rigorous description of the extent and types of health promotion activities nurses were engaged in, including any that represented health education and the manner in which these were conducted. Therefore this area remains largely unexplored by empirical enquiry.

Gott and O'Brien suggest that the fact that patients were reduced to discrete problem areas on which information was collected and to which nursing and medical practice could be applied is an organizational reality which is unlikely to change and which we should not concern ourselves with trying to. They suggest that:

"it is not necessarily the tasks or the information exercises engaged in by nurses that require change. Rather it is the structure that divides health actors into "expert" and "non-expert", "aware" and "ignorant" which should occupy our attention" (Gott and O'Brien 1990: 146).

They also comment that this division between nurse and patient was most clearly visible in the hospital setting because its institutional form compresses the relationships between actors into sharply demarcated roles. No empirical data is presented to support this assertion and it therefore again suggests a need to analyze the nature of any educational interventions which take place at ward level between nurses and patients and the extent to which these are either prescriptive or empowering.

Gott and O'Brien conclude that the nurses in their study were not engaged in health promotion work, as outlined by the Ottawa Charter (WHO 1986b) principles. These findings are explained with reference to nursing's inability to exercise control over their own agendas and work practices at organizational, professional and societal levels. They comment that in all the settings they observed, the nursing agenda is divided between the demands of its employing organizations and the priorities of its superordinate allied professions and that this militates against the application of health promotion principles to the daily tasks which nurses perform. This difficulty is considered to be compounded by nurses' position more generally as women in society:

“Nurses, as (predominantly) women within the division of labour, are structured into subordinate positions within the health care system and afforded little authority in or control over the health agenda set by the medical profession and by executive and legislative bodies” (Gott and O'Brien 1990: 150).

Thus, they argue, working in a health care system characterized by inequality, makes it difficult for nurses to engage in health promotion, one of the primary aims of which is to reduce the inequitable distribution of resources for health. This perceived lack of control could be linked to the concept of empowerment and the need for nurses to be empowered in order to fulfill their role in health promotion.

Gott and O'Brien recommend that some means of combating the embedded political inequalities between health professionals and between nurses and the interests of other organizations is required. They argue that there is no prospect of nurses developing a coherent health promotion role unless and until the status and authority invested in the occupation is increased. To explain the findings of her literature review, Williams (1987) (see above) draws a similar interpretation to Gott and O'Brien. She argues that nursing is oppressed by the same forces that make an atomistic model inappropriate for reducing health inequalities - those forces that result in self-determination for some groups in society and not others. The solution, Williams asserts, is for nurses to recognize this common causality and embrace a totalistic model of health promotion

which focuses on the structural changes required to promote health effectively and equitably. This would then:

“be helping to create a society that will make professional self-determination possible because such changes would attack the class and gender bases of the sub-ordination of the profession” (Williams 1987: 265).

Together with Gott and O’Brien, Williams also advocates a re-orientation within nursing away from a focus on the individual towards more collective patterns of working which would enable the structural influences on health to be tackled. However, this may be related to her polarized models of health promotion and the lack of conceptualization of how an empowerment approach to health education at the level of the individual may contribute to an individual’s health and health promotion on a wider scale (see above).

Overall, whilst Gott and O’Brien’s (op.cit.) conclusions are enlightening and represent an important study in a largely unexplored area, their focus tends to be on nurses’ involvement in health promotion, as opposed to health education, roles and activities. This is made clear in their description of what they consider nurses should be doing in the name of health promotion - eliminating inequalities, developing community control over health and its determinants, generating participatory structures and reorientated health services. This focus is also evident from the lack of detailed description of nurses’ interactions with patients. It would therefore seem important to further examine nurses’ role in health education and the way in which this is both conceptualized and practiced. This is particularly so in view of the current organization of hospital nurses’ work which suggests that it is at this level that they can have the greatest impact on promoting health. It may be easier for nurses working in the community than for hospital based nurses to be engaged in , for example, developing community control over health, as Gott and O’Brien suggest. This illustrates one of the difficulties of studying nurses working in a variety of different settings, in that some roles may be more appropriate for some groups of nurses than others. This suggests that a focus on hospital nurses specifically may have some advantages.

To summarize, studies by Kendall (1991), Macleod Clark et al. (1990) and Gott and O’Brien (1990) have employed direct observation and recording in order to describe aspects of nurses’ health education and promotion practice. In contrast to some of the studies utilizing self-report measures, these suggest that some groups of nurses approach their health education practice in a manner which is prescriptive rather than

participatory and collaborative. This highlights the need to incorporate methods which directly capture nurses' practice in addition to those which rely on nurses' accounts. However, none of these studies provide a comprehensive and detailed description of the development of nurses' health education and health promotion role in acute ward settings and this remains an area largely unaddressed by research.

### **Summary**

The majority of research into health education and health promotion in nursing has focused on the areas of patient education and information-giving. These are illness-focused activities which view compliance and/ or professionally determined behaviour change as the outcome measure. The methods employed to study these areas reflect these aims and concentrate on outcomes rather than process. In addition, these studies have tended to be small-scale, one-off evaluations of initiatives and involve specialized input by either the researcher or specially trained nurses. That is, they provide limited information about these activities in nursing generally and this research has been superseded by a broader theoretical understanding of what nurses' role in health education and health promotion can involve. However, advances in the conceptualization of health education, health promotion and nurses' potential role have not been matched by empirical work describing nurses' practice in this area.

A small number of studies have adopted a broader perspective and examined the perceptions and practice of nurses and other occupational groups engaged in health education and promotion. Whilst the evidence is limited, these suggest that doctors adopt an ideology of health promotion which is derived from a medical model perspective and which equates with the behaviour change model outlined in the preceding Chapter. Health education officers were found to prefer a broader approach which emphasised community development and structural determinants of health. It was suggested that, in view of the historical link between nursing and the medical profession, nurses' views about health promotion are more likely to be similar to doctors than health education officers.

Those studies focusing on nurses do not, for various reasons, provide a comprehensive picture of the perceptions and practice of nurses working in acute care settings and the relationship between the two. Research by Bradford and Winn (1992) and McBride (1993) report reasonably advanced perceptions about health promotion, but these are constrained by the highly structured nature of the questionnaires employed. Whilst Davis (1992) reports more mixed findings, the reliability of the data collection methods

employed is also questionable. Williams' (1987) revealed that an individualistic or atomistic model of health promotion was predominant, but her account relies on a selective review of the American nursing literature and utilized a polarized conceptualization of individual versus structural approaches to health promotion. In addition, none of these studies utilized direct observation of nurses' practice to explore this issue. Other studies by Kendall (1991) and Macleod Clark et al. (1990) have included observation of nurses' practice and have found that this is limited and lacking in a participatory approach. However, both studies focused on one particular aspect of the nurse's role in health promotion and the practice of hospital nurses specifically was not addressed.

Gott and O'Brien's study included a larger sample of hospital based nurses and also found that nurses' health promotion perceptions and practice were limited. However, there is a lack of detail about nurses' health education interactions with patients in a hospital setting and the extent to which these could be regarded as health promoting or otherwise. In addition, the link between perceptions and practice is not specifically addressed. Both Williams (op. cit.) and Gott and O'Brien point to the subordination of nursing as a profession to explain their findings.

To conclude, the potential contribution of hospital nurses to health education and promotion is vast, given their overall numbers and close and continuous contact with patients at a time when health and illness issues are to the fore. The literature reviewed in this Chapter indicates that there is a lack of research which addresses hospital nurses' perceptions and practice of their health education and health promotion roles. In the light of this, there is a need for further research to examine this issue. Investigation is needed to determine whether nurses' perceptions and practice equate with certain health promotion values and ideas and whether their interactions accord with principles of a new paradigm approach to health education as outlined in Chapter One. It is also necessary to explore the types of activities nurses are engaging in in the name of health education and health promotion in acute care settings.

Thus, this study examines hospital based nurses' perceptions and practice of health education and promotion and the influences involved in this. The following Chapter details the methods used to accomplish this.

## **CHAPTER THREE**

### **METHODS**

#### **Introduction**

The overall purpose of this study was to elucidate nurses' perceptions about health education and health promotion and to examine the way in which these concepts are being operationalized in acute care settings. More specifically, the study's aims were as follows:

To explore nurses' interpretations of the concepts of health education and health promotion and the ways in which they describe their perceived role and current practice.

To describe the reality of nurses' health education and health promotion practice in the acute care setting.

To examine the influences on the development of this role in practice, including the relationship between nurses' perceptions and their practice.

The conceptual framework which guided the study and the interpretation of the findings was based on an understanding of health education and health promotion as outlined in Chapter One. This framework has been constructed in the wake of the WHO Ottawa Charter for Health Promotion (1986b). The Charter highlights the structural level at which health promotion is believed to operate and acknowledges that health education (the development of personal skills) is a constituent element of this. The Charter also states that health promotion incorporates such activities as building healthy public policy and creating supportive environments for health. The overall aim of health promotion is broadly defined as:

“the process of enabling people to increase control over, and improve, their health” (WHO 1986b)

The conceptual framework which guided this study is also based on a model of health education which recognizes the centrality of self empowerment and a number of associated characteristics as the most ethical and effective means of promoting health at the level of the individual. More specifically, for the purposes of this study health education was defined as that which includes:

“providing information, exploring values and attitudes, making health decisions and acquiring skills to enable behaviour change to take place. (They involve) promoting self-esteem and self empowerment so that people are enabled to take action about their health” (Ewles and Simnett 1992: 23).

This definition, as discussed previously in Chapter One, indicates that health education operates at the level of the individual person, client or patient and that the education process involves certain important characteristics such as the clarification of values and the promotion of self-esteem. The research aimed to examine the extent to which nurses’ interactions were characterized by these and other health education principles as outlined in Chapter One. Additionally, the researcher was interested in the types of health education activities that nurses were involved in, such as information giving, patient education, advice on lifestyles and the facilitation of patient participation in care. The study also set out to explore the extent to which nurses recognize, and/ or practice in accordance with, certain health promotion values, such as holism and collaboration. Whilst this study was concerned with both health education and health promotion in acute ward settings, the methods used to describe the reality of nurses’ practice were focused primarily on health education at the individual level as opposed to health promotion activities at a broader level. This is discussed further below.

### **Approach to the Study**

The aims of the study necessitated that several areas would be investigated - that is, nurses’ perceptions, nurses’ practice and an exploration of the influences or reasons for the development of particular health education and health promotion practices. Thus, it was apparent that no one single approach would enable all of the research aims to be fulfilled and it was therefore necessary to adopt an eclectic stance, combining qualitative and quantitative approaches. The advantages of this approach, and its relevance to this research study, are outlined below.

### **Qualitative and Quantitative Approaches**

In the recent past the development of nursing research has been characterized by the emergence of two, apparently conflicting, approaches. As a neophyte discipline, nursing research was initially characterized by its attempts to imitate the tradition of the natural sciences and consequently a largely quantitative paradigmatic stance was adopted in the majority of the early work in this area. Subsequently, the emergence of more qualitative approaches was seen as a reaction to the inherent deficiencies of a



purely “scientific” paradigm deemed inappropriate to address many issues in the field of nursing. In the ensuing debate over the relative merits and applicability of each approach a polarization developed between advocates of quantitative research on the one hand, and those in favour of qualitative research methodologies on the other. As Filstead (1979) pointed out over a decade ago, terms which merely represent the nature of data have come to represent “extreme paradigms” of a separatist approach. More recently, this dichotomy has been criticized for being somewhat artificial and pointless and increasingly it has been argued that the nature of the research itself should dictate the methodology employed, rather than blind adherence to one approach or the other. In addition, the advantages of combining both qualitative and quantitative research methods have been recognized. For example Corner (1991) highlights this, stating:

“One solution proposed to resolve the developing polarity in social science research is that of combining methods, so that the advantages of each complement the other, while the inadequacies of individual approaches are offset” (Corner 1991: 720).

In view of the multi-faceted nature of this study a flexible approach was required which combined elements of each paradigm in the methods employed in order to yield data which would address the research aims. More specifically, in order to understand nurses’ perceptions about health education and health promotion a largely qualitative approach was necessary, because, according to Duffy (1986), it is primarily concerned with gaining knowledge and understanding of people, events and conditions. Qualitative methods were also considered appropriate for use on the case study wards as this stage of the research was concerned with attempting to describe nurses’ behaviour in the setting in which it naturally occurs, together with explanations for the reason for its development. The relevance of qualitative methods to the current study is highlighted by Field and Morse’s (1985) discussion of its purposes. They suggest that such methods should be used: (i) when the research question pertains to understanding a particular phenomenon or event about which little is known (ii) when the research is conducted in a naturalistic setting, so that the context in which the phenomenon occurs is considered to be part of the phenomenon itself, and (iii) to allow all aspects of the problem to be explored, and the intervening variables arising from the context are considered a part of the problem. Thus, the use of qualitative methods was pertinent to the current study in that, as discussed in Chapter Two, the health education and promotion role and practice of nurses working in acute care settings is largely unexplored to date. In addition, the aim of investigating the reality of nurses’ practice necessitated its study in the setting in which it naturally occurs, and understanding the

reasons for its development would inevitably incorporate a focus on the context of its development, thus again highlighting the relevance of a qualitative approach.

Nevertheless, it was felt that both the interviews and the case studies would benefit from the adoption of more quantitative approaches to certain aspects of the data collection and analysis. As outlined above, these can complement the use of qualitative methods in a study and help to compensate for some of the latter's inherent weaknesses. A weakness of qualitative research often cited is the difficulty of assessing the reliability and validity of the data. Therefore a measure of the frequency with which certain ideas or concepts occurred within both the interview data and some aspects of the data derived from the case study wards was introduced in order to enhance assessment of the reliability of the findings. This was carried out as part of the process of content analysis of both interview and questionnaire data and is described in greater detail later in this Chapter. Essentially however, content analysis refers to:

“a research technique for the objective, systematic and quantitative description of the manifest content of communication” (Berelson 1971:18).

Although generally regarded as a method of analyzing qualitative data, it allows for a degree of quantification, thus combining the advantages of both approaches. Subjectivity and low reliability are counteracted by the use of a number of controls. The researcher enhances objectivity by conducting the content analysis on the basis of explicitly formulated rules. The rules serve as guidelines to enable two or more persons analyzing the same materials to obtain the same results. The analysis is rendered systematic by the inclusion or exclusion of materials according to consistently applied selection criteria (Polit and Hungler 1993). It was therefore considered that content analysis would enable the research aim of exploring nurses' understandings of the concepts of health education and health promotion to be addressed whilst at the same time enhancing objectivity and reliability through the use of some quantification.

Bryman (1988) suggests that the use of qualitative and quantitative approaches together facilitates an examination of the relationships between variables. This point was applicable to this study. More specifically, the demographic data collected from the nurses involved in both the interview stage and those completing questionnaires on the case study wards was amenable to quantification and the use of descriptive statistics. These characteristics could also subsequently be examined in relation to the findings from the qualitative analysis of data in order to allow any relationships between perceptions and demographic characteristics to be identified.

Bryman's (op. cit.) further suggestion that the two approaches may be combined so that "macro" and "micro" levels of the objects under study are examined was also relevant to the current investigation. Thus, the quantification employed in the process of analyzing the interviews allowed the phenomena (health education and health promotion) to be understood at the macro level due to the large sample size and the resulting voluminous data base. Whilst the utilization of qualitative approaches on the case study wards (observation, audio-recordings and field notes) enabled the phenomena to be studied at the micro level - that is, at the level of individual nurses' practice on the ward.

Finally, the use of both qualitative and quantitative methods of data collection in the current study allowed some degree of triangulation of the data to take place in order to increase the validity of the findings. Triangulation was first suggested by Campbell and Fiske (1959) and has been broadly defined by Field and Morse (1985) as a situation in which:

"Qualitative and quantitative methods may be used simultaneously to address the same problem" (Field and Morse 1985: 16).

The basic premise underlying triangulation is its concern with approaching the object of interest from a number of different vantage points. Multiple perspectives converging on the same phenomenon enable more accurate conclusions to be drawn, thus enhancing the validity of the findings. The use of a number of different data collection methods on the case study wards, incorporating both qualitative and quantitative approaches, enabled the researcher to triangulate the data derived from these sources in an effort to enhance the validity of the findings. It was also considered that the use of multiple data sources would enable a more complete picture of practice to emerge which would not have been possible with the use of a single method alone. Denzin (1978) describes this as methodological triangulation - that is, the use of multiple methods to address a research problem. Duffy (1987) further suggests that methodological triangulation can take one of two forms: (i) the within method, where one method is taken and several strategies within that method are used to examine the data or (ii) the between method, where data is collected through more than one method to see whether there is convergence in the findings. During the case study stage of data collection, the between method of triangulation was employed in order to examine the phenomenon of nurses' health education and health promotion practice in the acute ward setting. More specifically, the following data collection methods were employed:

- (i) Self-administered questionnaires
- (ii) Non-participant observation
- (iii) Audio-recordings of nurse: patient interactions
- (iv) Post-observation interviews with selected nurses
- (v) Field notes

In order to address the research aims, data from methods (i), (ii), (iii) and (v) were triangulated for each ward in order to describe the types of health education activities nurses were engaged in. Whilst each method provided a slightly different perspective, the process of triangulation allowed findings from one source to be checked against another. Similarly, sources (i), (iv) and (v) were used in order to identify the main influences on nurses' practice on each of the case study wards from both the nurses' and the researcher's perspectives.

Although triangulation has not been widely applied to the study of nurses' health education and health promotion practice, a study by Hinds and Young (1987) highlights its usefulness in relation to this subject area. The study focused on the concept of wellness and health promoting activity in a selection of patients receiving health education input from community health nurses in a clinic setting. A combination of qualitative and quantitative methods were used involving self-report questionnaires, observation, archival records, field notes and structured interviews. Hinds and Young concluded that the benefits of triangulation included the ability to validate the study's findings and explain divergent findings in addition to providing information to rule out a rival explanation. This indicates its potential usefulness to the study of nurses' health education and promotion practice. The current study employed triangulation as part of an approach combining qualitative and quantitative methods in order to enhance the reliability and validity of the findings.

### The Use of Case Studies

In order to address the research aim of describing the reality of nurses' health education and health promotion practice at ward level and the influential factors involved in this a case study design was adopted in the second stage of the research. Polit and Hungler (1993) describe case studies as:

**“in-depth investigations of a person, group, institution or other social unit”  
(Polit and Hungler 1993: 150)**

Yin (1991) suggests that case studies are the preferred strategy in the following instances: (i) when “how” or “why” questions are being posed (ii) when the investigator has little control over events and (iii) when the focus is on a contemporary phenomenon within some real-life context. It is apparent that the research question described above fulfills all three of these criteria, thus rendering the case study an appropriate approach in the current investigation.

The unit of analysis adopted for the study of nurses’ practice was at the level of the individual ward and the nurses working within it. That is, each ward comprised a separate case study. This was considered appropriate as, in the researcher’s experience, types of practices may be peculiar to a ward and operate relatively independently of other wards or units within a hospital. The organization of hospital work is largely structured around wards as discrete entities and it was hypothesized that particular cultures or practices, as well as particular influences on nurses’ practices, would develop and be sustained at this level, as opposed to a broader hospital level for example. In addition, the logistics of data collection made the individual ward a suitable unit of analysis for the case study approach. It was envisaged that the in-depth investigation that characterizes the case study approach would yield sufficient data to allow a holistic understanding of nurses’ practice to emerge in a way not possible by the use of alternative approaches.

Furthermore, it was considered advantageous in the pursuit of the research aims to incorporate a multiple case design. That is, data were collected on three separate wards which each formed a case study and enabled some comparison between cases to be made in order to highlight differences in practices and possible explanations for this. The advantages of multiple site data collection are highlighted by Field and Morse (1985):

**“By using the case study method simultaneously in two or more settings, it is possible to compare and contrast the settings. The constant comparison of the (two) settings provides richness of data and important insights for theory development” (Field and Morse 1985: 88).**

Therefore it was considered that this approach had the potential to offer additional insights into the subject under investigation which would not be possible from the use of a single case study only.

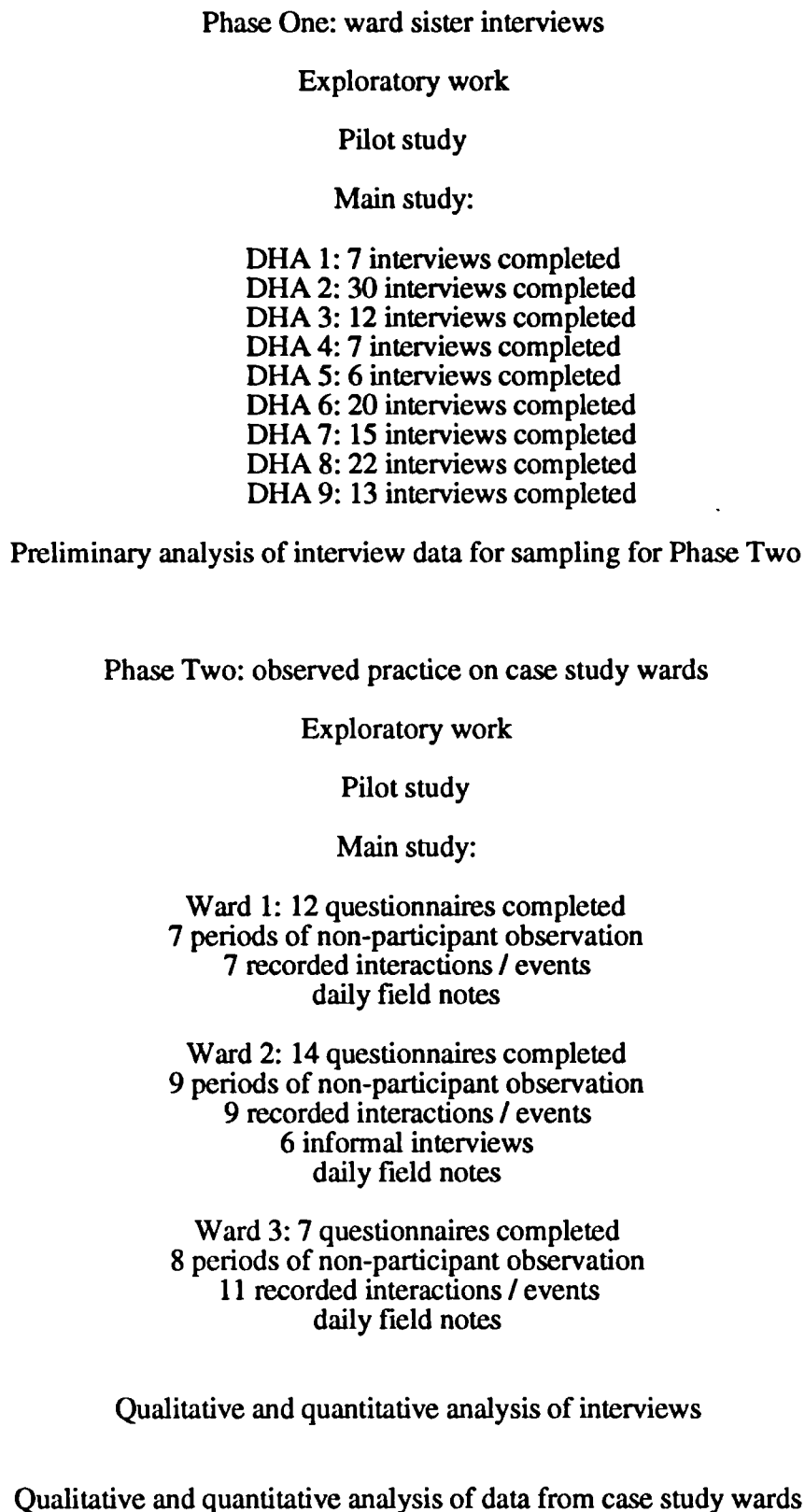
Potential disadvantages of the case study as a research strategy include the fact that the nature of the data collection requires intensive and prolonged periods of contact from the researcher, thus leading to the possibility of subjectivity in the recording and analysis of the data collected. Thus, the reliability and validity of the research may be threatened. Whilst this possibility cannot be entirely eliminated from this study, steps were taken to enhance the reliability and validity of the data collection methods such as exposing the data to independent experts, inter-rater reliability checks (see below) and the process of methodological triangulation. A second disadvantage of the case study approach lies in the fact that its representativeness of similar cases cannot be estimated or guaranteed. The in-depth nature of case study research usually necessitates either a single study unit or the use of only a small number of cases. The current study is therefore limited with respect to the generalizability of the findings and no claims are made for this. Rather, it was considered more important to gain an in-depth, comprehensive understanding of nurses' health education and promotion practice at ward level, and for this reason the case study approach seemed most appropriate.

To summarize, the research aims necessitated that the approach to the study incorporated a number of different features. These aims could best be met through the employment of both qualitative and quantitative approaches to data collection and analysis, which also allowed for some triangulation of the data in the case study stage of the research. Case studies were generated and used to enhance the description of the reality of nurses' practice and the influential factors involved in its development at ward level.

### **Design of the Study**

An outline of the study design is shown in Figure 1. The study employed a cross-sectional design in order to illuminate nurses' current perceptions and practice in acute care settings. The research divided into two distinct but related sequential stages: phase one comprised semi-structured interviews with a sample of ward sisters in nine District Health Authorities (DHAs), followed by data collection on a sub-sample of three case study wards in three DHAs. Thus the study progressed from an initial large scale focus to a more detailed analysis of the issue at the micro or ward level. Whilst the nature of the interview stage was descriptive, the case study wards combined both

**Figure 1: Design of the study**



descriptive and interpretive elements in relation to understanding the development of nurses' health education and promotion practice. In addition, the design of the study allowed a comparative element such that perceptions ascertained from the ward sister interview phase could be indirectly compared with the reality of practice observed on the case study wards. In addition, a comparison of data collected from each of the individual case study wards was possible in order to interpret differences and similarities with respect to nurses' practice.

### **Phase One: Ward Sister Interviews**

#### **Exploratory Work**

At the beginning of the study it was necessary to conduct exploratory work in order to assess the feasibility and appropriateness of the anticipated methods of data collection. A draft interview schedule was constructed and subsequently shared with nurses, nurse researchers and experts in the field of health education and health promotion within a Department of Nursing Studies, for comments and feedback on its face and content validity. Other tests of validity normally applied to quantitative data - such as content and construct validity - were not appropriate for the current study.

During this exploratory stage, a small sample of nurses were also interviewed using the schedule to assess the clarity of the questions and to what extent the data yielded reflected the research objectives. The feasibility of note-taking during the interview, the necessity of audio-recording the interview and the use of selected transcription of data were also monitored. Due to the characteristics of the intended sample - that is, ward sisters working in acute ward settings - it was considered important that the exploratory work was conducted with those who had recent clinical experience in such environments. Thus, the nurses interviewed comprised one ward sister, one charge nurse and one senior staff nurse currently working on acute medical and surgical wards in three different hospitals, a post-graduate student with recent clinical experience as a ward sister and three post-registration under-graduate students also with recent clinical experience in an acute ward environment. The nurses sampled worked in a range of different acute medical and surgical specialities in order to test the applicability of the schedule for the variety of different settings that would be encountered in the main study. These early interviews also gave the researcher the opportunity to practice and refine interview technique in preparation for main study data collection.



Comments received from colleagues suggested that the face and content validity of the schedule was satisfactory and needed little alteration. The interviews proved a useful preparation for the pilot and main studies in a number of different respects. The researcher found that the interview schedule elicited the desired data and that the clarity of the questions was also generally satisfactory. The interview schedule proved applicable to the variety of different clinical settings in which the respondents worked. It was apparent from the exploratory work that whilst note-taking during the interview was possible, this had the potential to disrupt the flow of the interview and inevitably meant that data was lost when the interview was not audio-recorded. In instances where the interview was both recorded and brief notes made simultaneously, the researcher was able to play back the recording and augment the notes previously made by selectively transcribing the recorded interview. This process of selective transcription proved satisfactory in that the richness of the data was preserved whilst at the same time eliminating material not directly relevant to the research question (see below for further details of this process). These findings were taken into consideration prior to the design and conduct of the pilot study.

### Pilot Study

The aims of the pilot study were to assess the clarity and comprehension of the interview schedule to nurses currently working in an acute clinical environment, and to ascertain a measure of the instrument's reliability and validity.

The sample of ward sisters who participated in the pilot study consisted of a convenience sample located within a large London teaching hospital. From a list of the total number of acute wards situated within the hospital and its smaller satellite hospital, a 50% sample were selected. This sampling procedure was partly random and partly based on conversations with senior nursing personnel who gave suggestions as to which ward sisters might be willing to participate. A total of 15 ward sisters working on a variety of acute medical and surgical speciality ward areas were interviewed as part of the pilot study.

Data were collected over a two week period during January 1991. Appointments were made with individual ward sisters at a mutually convenient time for the interview to take place on the ward. The interview schedule, refined through exploratory work, was utilized to structure the interview and consisted of open ended items to elicit the ward sister's perceptions of the concepts of health education and health promotion and the nurse's role in this. The exploratory and pilot work provided an opportunity to

enhance one aspect of the reliability of the interview phase of the research. That is, the reliability of the interview schedule (and questionnaire utilized in the second phase of the research) was enhanced due to their development over a period of time from exploratory work through to the pilot study and finally main study data collection. This process resulted in the ability to standardize questions to each respondent and also enabled the researcher to become familiar with the items included in the interview schedule. Deatrick and Faux (1991) state that a concern of the qualitative investigator must be the need for stable, similar conditions in administering instruments in order to increase data reliability and comparability. In accordance with this, they suggest that an interviewer must be completely familiar with the interview guide and know how and to what extent questions may be clarified. The period of exploratory and pilot work with the ward sister interviews served as a training and familiarization experience for the researcher such that in the main study some standardization of interview administration was possible, thereby enhancing the reliability of the data.

The interviews were audio-recorded using a Sony Cassette-Corder TCM 77V cassette recorder which incorporates an in-built microphone. Whilst this had the advantage of minimizing the obtrusiveness of the recording equipment, it also meant that any unwanted background noise was also picked up. Thus, it quickly became apparent that meaningful transcription of the interview required a quiet room where minimal interruptions would be likely. To a certain extent, this depended on the facilities available either on the ward or in the immediate hospital environment, but in the main study each ward sister was asked to consider this when the researcher negotiated an interview date. Brief notes were made on key aspects of the ward sisters' responses during the interview itself as a precaution in the event of failure of the mechanical recording equipment.

The 15 interviews were selectively transcribed with a focus on the relevance of the data to the research aims and objectives. Thus, material deemed relevant in any respect to perceptions of health education and promotion and the nurse's role in this was transcribed verbatim. Other data was either not transcribed or a note made as to the substance of the comments for possible future reference. In relation to the issue of "irrelevant" data, the researcher found during the course of the pilot study that a substantial amount of data, from some ward sisters in particular, was inconsequential and bore little relevance to the original question posed by the researcher. It was therefore necessary during the main study for the researcher to adjust the interview technique to minimize what Field and Morse (1985) refer to as "the dross rate". That is, the researcher continually focused the interview such that the production of

irrelevant information caused by the interviewee digressing from the original question was reduced.

### Revisions

To summarize, the pilot study highlighted the importance of the researcher stressing the importance of conducting the interview in a suitable setting which was relatively quiet and free from interruption if possible. In addition, it became apparent that the researcher needed to adapt the interview technique such that the respondent focused on the interview question and returned to it when comments began to deviate widely from it.

Findings from the pilot study suggested that the instrument yielded data that was comparable between the individual ward sisters and relevant to the research objectives, thus intimating its reliability and validity as a data collection tool. Therefore, it was deemed suitable for data collection in the main study, which is described below.

### The Main Study

Following the pilot study for the ward sister interview stage of the research, the main study proceeded, commencing in February 1991.

### Sample and Access

The DHAs selected for inclusion in the interview stage of the research were derived from a sampling frame provided by responses to a national postal survey of senior nurse managers carried out as part of a larger study (see Macleod Clark et al. 1992). To ensure a geographically representative spread of Districts throughout England from those who had indicated a willingness to participate, a system of stratified sampling was utilized. That is, Districts were stratified according to their geographical location and then randomly sampled within each strata. Within each District a 50% sample of ward sisters on acute wards was selected for interview, based partly on stratified random sampling according to the clinical speciality of the wards and also on conversations with managers and practitioners who expressed an interest and desire to participate.

The procedure for gaining access began in DHA 1 and followed a similar pattern in the remaining Districts. The researcher initially established telephone contact with the

nurse identified as completing the postal questionnaire in the preceding national survey. In the majority of cases, this was a nurse at senior management level. Agreement to proceed with access was verbally confirmed and the researcher sought to establish an appropriate individual with whom to liaise for access and sampling. The researcher was dependent on the co-operation of the liaison or contact person in view of the geographical distance of some of the DHAs. This meant that initial liaison with the ward sisters and the convening of an introductory meeting was often the responsibility of this contact person. The researcher also requested a list of the acute wards within the DHA from the contact person which would provide the sampling frame for each District. At this stage it was important to clarify what was meant by the term "acute ward". The term "acute" was used to distinguish wards from those settings in which the nature of care is more accurately described as long-stay and/ or rehabilitative in nature. However, more precise guidelines as to inclusion criteria were required due to the diverse and heterogeneous nature of acute care settings both within and between different DHAs. Thus, it was decided that wards to be included would consist primarily of adult general medical wards and general and speciality surgical wards. Paediatric and psychiatric wards, as well as Accident and Emergency Departments were excluded as the researcher felt that their inclusion would introduce different issues relevant to health education and promotion which would warrant separate studies in themselves.

Having obtained a list of the wards meeting these criteria, a 50% sample of wards within each DHA were selected. Whilst the research does not claim to be representative of all ward sisters working in acute ward settings, it was felt that a 50% sample would yield a reasonable cross-section of wards within each District and an overall satisfactory sample size. Where appropriate, wards were stratified according to type (general medicine, general surgery and specialist surgery) in order to ensure a range of different types were included in the sample for interview. As indicated above, sampling was based in part on conversations with the contact person who indicated ward sisters who may like to participate, and partly on a random basis. In conjunction with the contact person, an introductory meeting was arranged with the potential ward sister interviewees selected. The meeting provided an opportunity to explain the nature of the research, the manner in which the potential interviewees had been selected, and what consent to participate would involve. In addition, the researcher was able to answer any of the questions that the ward sisters may have had. The researcher explained that the study was concerned with nurses' health education and health promotion practice in acute ward settings and emphasized that the aim was to gain understanding of how practice was developing rather than to judge individual wards

according to levels achieved. Verbal consent to participate and a mutually convenient interview date was negotiated with each individual ward sister at the meeting. Where this was not possible, a follow-up telephone call was made to arrange this.

Simultaneous with this process, the District Research Ethics Committee within each DHA was approached regarding the proposed research. Five of the ten DHAs requested that details be submitted for approval to the Committee prior to proceeding with the interviews. The remaining five considered that the interview stage could proceed since it did not directly involve patients, but that submission would be required if any of the Districts were to be used for the case study data collection. The research was approved without any major ethical concerns by the five Committees involved, given that the researcher stressed the importance of informed consent and confidentiality of the data collected. In one DHA, in which the Committee was composed of medical as opposed to nursing personnel, the proposed study was deferred pending the researcher's presence at the next meeting. This was considered necessary due to a lack of recognition on the part of the medical committee members of any role for nurses in relation to health education and health promotion. The researcher's attendance provided the necessary clarification and the research was approved. However, this prolonged the process of gaining access and highlights the desirability of the establishment of nursing research ethics committees whose members presumably would have greater insight into areas of interest to nurse researchers.

During the process of negotiating access, one of the 10 DHAs originally selected for inclusion declined to participate in the study. After consultation with ward sisters likely to be involved, the nurse manager identified as the contact person informed the researcher that other changes associated with the DHA's transition to a self-governing trust status meant that the sisters felt unable to give the necessary time and commitment to the research. Thus, data collection proceeded with nine of the original DHAs.

### Ethical Issues

The Royal College of Nursing's (1977) guidelines incorporated in "Ethics Related to Research in Nursing" were utilized as a framework to ensure that the researcher addressed the ethical issues arising during the course of the study. In particular, the nature of the research and the methods of data collection used gave rise to a number of ethical issues highlighted by the above guidelines. Those that were pertinent to phase two of the study are discussed below. In relation to the interview phase of data collection, the prime concern centred around the notion of informed consent. Thomas

(1990) cites the American Code of Federal Regulations (1981) which defines informed consent as:

“the knowing consent of an individual or his/her authorized representative, under circumstances that provide the prospective subject or representative sufficient opportunity to consider whether or not to participate” (Thomas 1990: 64).

She goes on to suggest that potential participants should be offered full knowledge about such aspects as the identity and credentials of the investigator, the purpose, duration and expected benefits of the research, the procedures that will involve the subjects, potential inconveniences and risks, projected use of the study findings and sponsorship of the research. In accordance with this, the researcher produced a written summary outlining details of the current investigation (see Appendix 1). Prior to interview, it was considered important that each individual ward sister was able to give informed consent to participate. The nature of the sampling process and access to the hospital site (see above) raised the possibility that more senior nursing personnel could consent on the ward sister's behalf. To avoid this, meetings were held at each hospital site to offer the ward sisters both written and verbal details of the research and an opportunity to raise questions and queries. Following this, individual consent to be interviewed was sought either at the time of the meeting or with a follow up telephone call. A similar process was employed in relation to the informed consent of individual nurses working on the case study wards (see below).

A second ethical consideration related to confidentiality of the data collected from the ward sisters. This was particularly pertinent in view of the fact that this was tape-recorded and therefore a permanent record was held. Anonymity was achieved by coding of individual nurses' names on both the audio-cassettes used for recordings and the transcripts on which the data were stored. Confidentiality of the data was protected by ensuring that it was used only for the purposes of the research itself, and in accordance with this, only the researcher and a small number of colleagues involved in assessing the reliability of the analytic process had access to the transcripts. The data derived from the interviews were also stored under lock and key at all times in order to maintain security.

A concern over confidentiality of the interview data arose during the course of data collection in one DHA. This arose when a nurse manager - who had been instrumental in helping the researcher obtain access to the ward sisters - requested feedback on the

findings from individual wards within the hospital regarding the extent to which health education activities were developing. The researcher felt that this would be ethically unsound in view of the assurance of confidentiality offered to the ward sisters at the time of the interview. Allowing feedback to the nurse manager may also have compromised the validity of the data if the ward sisters had knowledge that this was to occur. That is, they may have been more inclined to exaggerate the extent and nature of health education and promotion on their respective wards in order to create a favourable impression for the researcher to report back to their manager. On the other hand, the researcher felt indebted to the manager for her help in the access process and was aware that all participants in the research had a right to be informed of the findings. Therefore a compromise was reached such that the manager was given a concise summary of the researcher's impressions of what was happening on the wards *as a whole*. This meant that individual wards were not identified, and the researcher stressed that this was a subjective impression prior to any form of detailed analysis. In due course, the manager was sent a summary of the findings from the interview phase in its entirety. Other than this, there were no other concerns over ethical issues arising during the first phase of data collection.

#### Data Collection Method

The aims of the research and the approach to the study guided the methods used. The method of data collection employed in phase one of the research was semi-structured interviews.

The aim of this first stage of the research was to elicit nurses' perceptions about the meaning of health education and health promotion and nurses' role and practice of these activities, and therefore interviews were the most appropriate form of data collection. The format of the interview could best be described as semi-structured in nature (see Appendix 2). That is, open-ended questions were formulated for use with each participant in a standardized manner following a certain set sequence. May (1991) discusses the challenge of maintaining a balance between flexibility and consistency in data collection posed by the use of qualitative interviews. She states:

“Flexibility in topic selection and in questioning is essential for discovery and for eliciting the individual informant's story. However, some consistency is also essential in types of questions asked, depth of detail and the amount of exploration versus confirmation covered in an interview in order for conclusions to be drawn” (May 1991: 192).

The researcher considered that the use of a semi-structured schedule would help achieve the necessary balance between flexibility and consistency. The use of open-ended questions initially allowed the topic to be explored from the respondents' perspectives without constraining responses by pre-determined criteria. This has been a criticism of previous work in this area (see Chapter Two). However, the inclusion of certain items focusing on specific activities and the standardization of the question order guaranteed that areas of interest pertinent to the research aim would be covered by each of the respondents. The uniformity of the questions also enabled the meaningful quantification of some aspects of the data and allowed comparison of data derived from different respondents or groups of respondents where appropriate.

Due to the desire to collect personal details about each of the respondents, two short closed questions were included at the beginning of the interview. As Thomas (1990) points out, bland information should always be sought in an interview before sensitive questions are posed. The collection of personal information would enable these variables to be studied in relation to responses to the more open-ended items (see above).

As described above, the decision was taken to audio-tape the interviews using a small tape cassette recorder, as this provided greater depth and detail of response for later transcription and analysis than would have been possible through the use of note-taking alone. In addition, the exploratory and pilot work (see above) highlighted the difficulties involved in attempting to write sufficiently detailed notes whilst at the same time maintaining the flow of the interview. However, the introduction of a tape-recorder poses some disadvantages which may influence the validity of the data collected. That is, it has the potential to distort the natural responses of the interviewee due to the latter's awareness of its presence which may cause embarrassment and / or a reluctance to disclose potentially sensitive or confidential information. Attempts were made to overcome these problems by the use of several measures. Unobtrusive recording equipment with an in-built microphone was used such that there was no necessity for the respondent to have a microphone or wires attached to their person, thereby helping to minimize awareness of its presence. The researcher's experience during exploratory work also indicated that careful, discrete positioning of the recorder was also essential to avoid either party being distracted by it. Each ward sister was also assured of the confidentiality of the data in an attempt to minimize responses being constrained by concerns over this. Any decision to decline to be tape-recorded due to embarrassment or anxiety was respected. Such refusals were in fact rare (n=3) and most respondents did not appear unduly concerned by the request to record the



interview. Many also commented at the end of the interview that they had ceased to be aware of its presence. Overall, it was considered that the advantages of recording the interview outweighed the potential problems that may arise as a result of the presence of a tape-recorder.

The introductory closed questions to elicit personal details about each respondent were followed by a number of open-ended items which focused on the ward sisters' perceptions of the concepts and of nurses' role and practice of health education and promotion. These were as follows:

Meanings attributed to the terms "health education" and "health promotion."

Description of the types of health education and health promotion activities that nurses were engaged in on their respective wards.

Description of the perceived difficulties in developing this role in the ward setting.

Description of the factors that are perceived to be helpful for nurses to integrate health education and health promotion into practice.

Respondents were also subsequently asked about the practice of certain health education activities which were selected for inclusion by the researcher. As these were included in the latter part of the interview, they did not have the effect of influencing the ward sisters' own perceptions of the concepts and their role, which were ascertained at the beginning of the interview.

Early exploratory work with a number of ward sisters in the clinical setting indicated that it was essential to begin the interview with a clarification of respondent's understanding of the terms. Whilst this may represent a potentially demanding question to some respondents, it was necessary in order to conduct the remainder of the interview on a meaningful basis. That is, the responses to subsequent questions were determined to a large extent by the ward sister's own frame of reference and therefore this needed to be ascertained at the outset of the interview. It is also apparent that this question yielded data which would directly address the central research aim of understanding the ideas with which nurses were operating in relation to health education and health promotion. On the other hand, asking respondents to describe the

types of activities occurring on their wards and the inhibiting and facilitating factors involved in this provided data from which meanings ascribed to the concepts and nurses' role could be indirectly inferred. It was considered that this would allow themes emerging from one question to be verified by reference to other questions thus lending reliability and validity to the findings and enabling a comprehensive understanding of their perceptions to emerge.

In summary, a semi-structured interview was considered to be the most appropriate method of data collection for the interview phase of data collection. This enabled the research aim of eliciting nurses' perceptions about health education and health promotion to be addressed, whilst at the same time facilitating comparison and quantification of responses.

### Data Collection Procedure

Interviews with ward sisters in the nine DHAs comprising the main study sample commenced in February 1991 with DHA 1 and were completed in August 1991 in DHA 9. The majority of interviews were conducted in the vicinity of each respondent's ward at a time convenient to the ward sister. As a result of the pilot study, every attempt was made to conduct the interview in an environment free from noise and interruption. However, this did not always prove possible, as is discussed more fully below. Interviews were tape-recorded with the ward sister's consent using equipment as described in the pilot study. The tape-recording of the interviews provided a further method of ensuring the reliability of the data. Deatrick and Faux (1991) suggest that interviews recorded in this way:

“increase data reliability by preventing selective filtering of data due to investigator recall or summarization” (Deatrick and Faux 1991: 217).

The accuracy of the recordings was addressed by attention to the quality of the recording equipment, its proximity to the interviewee and careful maintenance and monitoring both during and between interviews.

Following the interview the researcher was sometimes shown around the ward and/ or given samples of relevant health education and promotion literature to substantiate remarks made during the interview. Brief notes were made about such experiences by the researcher as an adjunct to the interview transcript and this proved useful in enhancing the validity of the interview data as well as contributing to the researcher's

overall impression of the way in which nurses were developing their health education and promotion role in acute ward settings.

### Problems with Interview Data Collection

During the course of data collection for the main study, two main problems arose in relation to the interview stage of the research. The first concerned problems with the recording of the interview. In six instances (5%) the interview was not recorded due to either the ward sister's preference ( $n = 3$ ) or failure of the recording equipment ( $n=3$ ). On these occasions, the researcher attempted to make notes simultaneously with the interview, as sufficiently detailed as this would allow. Immediately following the interview, these were augmented from the researcher's memory as far as possible. It was felt that the data derived from these interviews were sufficiently adequate to shed light on the research questions, although it is recognized that in such cases, the richness and reliability of the data was somewhat compromised.

A further problem proved to be the level of background noise and number of interruptions experienced during the course of individual interviews. Whilst the pilot study indicated the need to conduct the interview in a quiet location free from interruption and noise and the researcher stressed this in the process of arranging an appointment, this did not always prove possible. The recording equipment used enabled the problem of interruptions to be minimized to some extent: a pause button on the recorder was utilized during the interruption or distraction. In addition, as the flow of conversation was interrupted, the researcher needed to develop skill in re-establishing the discussion such that data was not lost. During the process of transcribing the data, it was felt that the problem of interruptions had been minimized to the extent that the data collected during these interviews remained amenable to analysis. Nevertheless, the experience highlights the importance of both the environment in which the interview is conducted and the use of appropriate recording equipment in order to yield meaningful data.

The second problem encountered relates to the validity of the data collected. More specifically, the researcher felt on occasions that there was the potential for inaccurate descriptions of nurses' practice by the ward sister due to the possibility of social desirability response bias. Field and Morse (1985) suggest that the "researcher's status position" can prevent certain information from being obtained thereby influencing the validity of qualitative data. The researcher's position as an "outsider" and as a nurse had the potential to distort the information elicited from the ward sisters during the

interviews in this way. Attempts to minimize distortion involved the researcher emphasizing that she was interested in an account of reality and the difficulties involved in enacting health education and promotion. The opportunity was also taken to confirm that the interview was confidential and that findings from individual wards would not be shared with individual nurse managers. The researcher's position as a nurse could also have had a beneficial effect in that the ward sister may have felt that she would be aware of the difficulties and problems faced, and would thus be more likely to disclose honest information. Nevertheless, the researcher was always cognisant of the threat to validity posed by her position, and, as Deatrick and Faux (1991) point out, this source of bias or distortion cannot be eliminated.

Whilst it is recognised that respondents' reports of what they say they do may not be an entirely accurate representation of reality, it was hoped that an atmosphere was created in which the ward sister felt able to give honest and accurate responses. It should also be stressed that the primary aim of the interviews was to understand nurses' perceptions about health education and health promotion and the nurse's role in this rather than claiming that the data necessarily represent an accurate representation of the reality of practice. (The relationship between nurses' perceptions and their practice is discussed further in Chapter Six.) Thus, the validity of the data lies in the extent to which nurses' perceptions, as opposed to the reality of practice, were captured. The latter was addressed during the case study ward stage of data collection.

### Analysis of the Interview Data

Manual transcription of the interview data took place simultaneously with the process of data collection in each of the nine DHAs. As previously mentioned, the transcription was selective with only comments pertinent to the research aims and objectives utilised for subsequent analysis. Whilst it is recognised that decisions about the relevance or otherwise of certain data are somewhat subjective, if in doubt the researcher transcribed the comments for referral to during analysis. In addition, a second researcher, familiar with the subject area, was available to discuss the relevance of certain comments to the research aims, thus introducing an element of reliability. In practice, it was found relatively easy to distinguish between relevant and irrelevant material. Whilst the researcher attempted to focus the interview, the latter usually occurred when the researcher was being used as a sounding board for a number of different issues or problems facing the ward sister and the respondent strayed considerably from the question asked. Examples of such material which was not transcribed ranged from a ward sister experiencing a personality conflict with her manager to another who

described at some length the consultant's hobby of horticulture. Where appropriate, notes were made about the nature of the material not transcribed for possible future reference. All other comments were transcribed verbatim under the appropriate section of the interview schedule.

On completion of data collection there were 132 such transcripts. The data were subsequently analyzed using a process of content analysis in order to derive categories from the data which enhanced understanding of the ward sisters' perceptions of the concepts of health education and health promotion and acute-based nurses' role in this. The characteristics of content analysis, its applicability to the current study and an outline of the analytical process employed are described below.

The analytic method of content analysis has been described as:

“a research method for investigating problems by systematically and objectively identifying characteristics of the message for the purpose of making inferences” (Holsti 1968, cited by Cole 1988).

The method combines both qualitative and quantitative approaches to analysis. As the above definition suggests, it is normally applied to narrative, qualitative data and it typically involves a measure of quantification of this, thus distinguishing it from a purely qualitative approach. As Weber (1990) points out, the best content-analytic studies use both qualitative and quantitative operations on texts, thereby combining what are normally thought to be antithetical modes of analysis. The advantages of combining qualitative and quantitative approaches in the current study have previously been described. Essentially, content analysis was considered a suitable method as it would allow an understanding of the nurses' perspectives to emerge whilst at the same time enabling the researcher to depict the representativeness or dominance of certain response categories.

Content analysis may be used to analyze a wide variety of narrative materials ranging from historical documents to personal diaries and the content of speeches. As the latter indicate, it may be applied to material that has been produced independently of the purposes of the research investigation and this has the advantage of avoiding bias in the communication of the message to suit the purposes of the research. However, this was not applicable to the current study. Content analysis may also be applied to material derived for a particular purpose: for example, Berelson (1971) suggests that it may be used to code open-ended questions in surveys. Content analysis was therefore selected

as applicable to the current study. A more purist form of qualitative analysis was rejected for a number of reasons: the semi-structured nature of the interview schedule and the items included confined both the length and depth of the response, rendering a purely qualitative approach less appropriate. In addition, the relatively large number of interviews and the comparability of responses as a result of the semi-structured schedule made some form of quantification both necessary and desirable. Introducing an element of quantification facilitated the organisation of the database without detracting from the richness provided by the qualitative aspect of the analysis. On the other hand, a purely quantitative method of analysis was not consistent with the research aims of the need to elicit understandings of the concepts and of nurses' role and the consequent open-ended nature of the items included in the schedule. Therefore, content analysis, combining elements of each approach, was considered the most applicable method of analysis for both the interview data and for questionnaire data (see below).

The procedure involved in coding the content of the message from each of these sources was adapted from the steps outlined by Cole (1988). These were:

1. Develop the coding scheme:
  - a) Recording unit
  - b) Categories
  - c) Context unit
  - d) Enumeration unit
2. Develop the coding sheet.
3. Specify coding instructions and definitions for each category.
4. Organize and analyze data.
5. Interpret the results.

To begin with, the unit of analysis must be specified. This may vary according to the purpose of the analysis and can range from the analysis of individual words contained within the text to a unit comprising the item itself, i.e. the whole document or object of analysis. For the purposes of the current study, the unit of analysis selected was that of the *theme*. Polit and Hungler (1993) describe this as a broader unit of analysis than a word which can comprise a phrase, sentence or paragraph embodying ideas or making

an assertion about some topic. This was considered appropriate in attempting to understand ward sisters' ideas about health education and health promotion and the nurse's role in this. That is, these ideas would transcend individual words, sentences or paragraphs and were not likely to be uniform in length thereby making analysis on the basis of the latter inappropriate. However, the unit of analysis varied according to the nature of the data being analyzed. Thus, the personal details of each respondent were coded on the basis of individual words or sentences, as opposed to themes.

Secondly, categories were then developed to classify the unit of message content. Whilst content analysis may involve the application of pre-determined categories to the narrative material, this was not appropriate for the current study which aimed to enhance understanding from the perspectives of the nurses themselves. Thus, the process was adapted to allow for this. As Weber (1990) points out:

“There is no simple *right way* to do content analysis. Instead, investigators must judge what methods are most appropriate for their substantive problems” (Weber 1990: 13).

To allow for a more inductive approach, the categories were developed following an initial analysis of a sample of the interview transcripts. For example, in relation to meaning attributed to the concepts of health education and health promotion, a major category to emerge was that of “information giving”. It became apparent that this could be further broken down into (i) information about lifestyle or personal habits and (ii) information about illness and coping with illness. The categories to emerge in this way then formed the basis of a coding framework which was applied to the remainder of the transcripts as part of the process of content analysis. Weber (1990) suggests that testing of the category definitions not only reveals ambiguity in the rules but also often leads to insights suggesting revisions of the classification scheme. Therefore the categories were continually checked for their fit and comprehensiveness and refinements made as necessary.

Cole (1988) suggests that proper interpretation is essential to select the correct category to classify the recording unit and for this reason the next step in content analysis is to identify the context unit. This is defined by Holsti (1968 cited by Cole 1988) as that which represents the maximum amount of the message that may be searched in order to interpret the recording unit defined. With respect to the ward sister interview data, the context unit within which each theme could be interpreted was the total response to each item included in the schedule. For example, the meaning attributed to the concept of

health education could be interpreted within the context unit of the item asking the ward sister to describe their understanding of the terms health education and health promotion.

Following this, the enumeration unit was delineated. This refers to the measure of quantification which will be applied to the data. Polit and Hungler (1993) identify four types, the most common of which is the enumeration of recorded occurrences in each category of the category system. A second approach is to create a binary index (yes/no) of whether the concepts covered in the coding scheme were present or absent in the materials. Other possibilities include the ranking of materials according to pre-specified criteria or the application of rating scales to assess various aspects of the communication. In the current study, the first two methods were employed in the analysis of various items included in both the interview schedule and the data derived from the case study ward questionnaires. That is, themes emerging from the data were recorded according to the category to which they related such that an overall indication of the frequency with which each category was identified was possible. Some items included in both the interview and the questionnaire were also amenable to a binary system of classification - for example, the case study ward questionnaire asked for a yes/no response to the question of whether or not nurses had a role in influencing the hospital policies that affect health. The use of ranking or rating scales was not considered appropriate as a method of enumeration due to the large degree of subjectivity that this would inevitably introduce and the fact that it would contribute little to the research aims.

In accordance with the steps outlined by Cole, a coding sheet was developed delineating the categories for each separate question included in the interview schedule. Each occurrence of a category was recorded by placing a code number unique to each ward sister under the appropriate category heading. In this way the source of each of the responses could be identified. Simultaneously, coding instructions and definitions for each category were developed to ensure that the process of coding was systematic and to introduce an element of objectivity. This also allows an assessment of intercoder reliability to be conducted (see below). Using this method, the data derived from the ward sister interviews and the case study ward questionnaires were analyzed, resulting in the emergence of dominant categories which reflected these nurses' understandings of health education and health promotion and the nurse's role and practice of these activities. The findings were interpreted in relation to the literature on health education and health promotion which outline a framework for health promotion and models of health education (see Chapter One).



Weber (1990) suggests that the central problems of content analysis originate mainly in the data-reduction process by which the many words of texts are classified into much fewer content categories. Discussing the consistency or reliability of text classification, he states:

“In content analysis, reliability problems usually grow out of the ambiguity of word meanings, category definitions or other coding rules” (Weber 1990: 15).

Krippendorff (1980) further suggests that three types of reliability are pertinent to content analysis: stability, reproducibility and accuracy. Stability refers to the reliability as a result of consistencies produced when the researcher codes the same text more than once. However, inconsistencies may stem from a variety of causes other than the reliability of the coding system - such as memory or cognitive changes on the part of the researcher - and stability is the weakest form of reliability as only one person is coding. Accuracy is the extent to which the classification of text corresponds to a standard or norm and is the strongest form of reliability (Weber 1990). Due to the nature of the interview data, a standard coding for the interview or questionnaire data was unavailable and therefore the reliability of the procedure in terms of its accuracy could not be assessed. Instead, attempts were made to assess the reliability of the coding procedure using the criterion of reproducibility, also known as inter-coder reliability. Thus, a sample of six interview transcripts were analyzed by a second researcher utilizing the categories and coding instructions drawn up for this purpose. A large measure of agreement was achieved between the two researchers' classification of data into categories, thus suggesting that the analytic process possessed some degree of reliability.

The validity of the content analysis process is more difficult to assess. Attempts were made to assess this in the following ways: the categories developed from the data, together with a sample of the transcripts from which they were derived, were shared with a group of nurse researchers within a Department of Nursing Studies. Their feedback and comments to the researcher suggested that the coding system devised possessed face and content validity. A measure of semantic validity was also ascertained in this way. Krippendorff (1980) states that this exists when persons familiar with the language and texts examine lists of words (or other units) placed in the same category and agree that these words have similar meanings or connotations. Finally, the categories derived could be said to have a measure of construct validity in the light of the findings from the case study wards which showed that, in certain respects, the activities and enactment of health education and health promotion in the

clinical setting bore a close resemblance to the categories derived from the interview data. This is discussed more fully in Chapter Six.

To summarize, the interview data were analyzed using a combination of qualitative and quantitative methods adopted as part of the process of content analysis in order to describe the predominant ways in which ward sisters were interpreting the concepts of health education and health promotion and nurses' practice and role in this. The end result of this process of analysis was the emergence of a number of dominant categories. These are presented in Chapter Four together with measures of the frequency of their occurrence and illuminative quotations in order to increase the validity of the findings.

### **Phase Two: Case Study Wards**

The second phase of the research focused on observation and description of nurses' health education and promotion practice on three wards which were selected as case studies. Through the use of this approach, and by some comparison between cases, influences on the development of nurses' practice were also identified. A more detailed description of this stage of the research follows below.

#### **Exploratory Work**

A surgical ward within a large London teaching hospital from which ethical clearance for the study to proceed had been gained as well as colleagues within a Department of Nursing Studies were used for exploratory work prior to the pilot and main study on the case study wards. The feasibility of observing and recording nurses' health education and health promotion practice on the case study wards as well as decisions about the most suitable method of collecting the data were assessed.

A draft questionnaire was administered to colleagues with recent clinical nursing experience within a Department of Nursing Studies in order to ascertain its clarity to potential respondents and relevance to the research objectives. Comments on its face and content validity were also requested. The researcher also spent several days on the aforementioned ward, in order to explore different methods of collecting and recording data. Several methods of observation were conducted utilizing varying degrees of participation, different observation locations and the simultaneous observation of varying numbers of nurses and patients in order to assess the feasibility of each

method. The feasibility of recording the observation data in the form of long-hand notes, either simultaneous with the observation period, or immediately afterwards in the case of participant observation, was also assessed. The period of exploratory work also involved testing the viability of tape-recording nurse and patient interactions as a method of collecting data about nurses' health education practice. Several different events were selected and recorded and the audio tapes played back to assess the sound quality of the recording and the relevance of the material recorded to the research aims and objectives. Throughout the period of exploratory work, the researcher sought the opinions of the nurses working on the ward and attempted to utilize their knowledge in relation to the most appropriate means of assessing their health education and promotion practice and the feasibility of the research methods.

The exploratory phase in preparation for the case study data collection allowed the researcher to refine the methods to be used for the collection of data. Comments and written responses from colleagues within the Department of Nursing Studies indicated that the questionnaire was both comprehensible and relevant to the research aims. Respondents also indicated that the questionnaire had both content and face validity as a means of eliciting nurses' perceptions about their health education and promotion role and practice. Exploratory work on the ward indicated that non-participant observation was the most suitable approach to recording data about nurses' activities, including those of a health education type, and that it was feasible to make notes about these activities simultaneous with the period of observation. This early work indicated that the most appropriate unit of observation was a small group of three to four patients in close geographical proximity to each other. It was found that they were likely to interact with no more than two or three nurses during a two hour period of observation. It proved unmanageable to focus on larger groups of patients or nurses due to the great number of interactions and activities that were simultaneously taking place in addition to problems with audibility of conversations. Conversely, observation of a single nurse was also unsatisfactory in that the researcher was required to follow her to many different locations on and off the ward, making recording difficult and increasing the nurse's awareness of the researcher's presence to a level which may have resulted in reactivity, thus influencing the validity of the data recorded in this way.

Finally, the exploratory work also confirmed the feasibility of audio-recording interactions as a method of collecting data about nurses' health education practice. However, certain interactions or events proved unsuitable for recording due to the high levels of background noise and/or the mobility of the participants - for example during a ward drug round. The researcher also concluded that it proved appropriate in some

instances for nurses to record their own interactions with patients without the researcher's presence. This had the advantage of reducing the reactivity caused by the observer's presence during the recorded interaction.

### Pilot Study

The exploratory phase proved to be a valuable preparation prior to the conduct of the pilot study on the same case study ward. This was to a large extent a continuation of the exploratory phase. The aim was to properly operationalize the methods chosen to collect data in the exploratory phase and to make further refinements if necessary. In addition, the researcher wished to ensure that the questionnaire had clarity and meaning to nurses working in an acute clinical ward setting.

The collection of data for the pilot study took place during September 1991. The questionnaire used for exploratory work was distributed together with an explanatory letter either personally or via the internal mail system to qualified and student nurses working on the ward at the time. A total of 12 nurses were given or sent questionnaires and, after the distribution of a follow-up two weeks later, a response rate of 50% (n=6) was achieved. Whilst this was considered adequate for the purposes of the pilot study, it was felt that a personal introduction to the questionnaire from the researcher may have increased the response rate and therefore this was a change employed in the main study. Analysis of responses to the questionnaire indicated that the question wording was clear to respondents and that the items included elicited relevant data about respondents' interpretations of their role in health education and health promotion. Therefore the questionnaire was considered suitable for use in the main study with no alteration to its design (see Appendix 3).

Following exploratory work to decide on the most feasible method of observation, the pilot study was also used to collect data utilising two hour periods of non-participant observation of a small group of patients and the nurses who interacted with them. Recording sheets were specifically designed for this purpose (see Appendix 4) and five such observation periods carried out, spanning different times of the day from early morning to early evening. Notes were made on nurses' activities and interactions with patients during these periods, with more extensive, detailed recordings of any interaction which displayed characteristics relevant to health education. Following each observation period, the researcher collected relevant background details about the patients and nurses involved for subsequent use in conjunction with analysis of the observation data if necessary. An examination of the observation data collected

suggested that this was a feasible method of recording information on nurses' activities in conjunction with more detailed audio-recordings of interactions, as outlined below.

As a continuation of the exploratory work, audio-recordings of selected nurse: patient interactions were made using the Sony Cassette-Corder TCM 77V cassette recorder. Interactions were selected on the basis of their feasibility of recording as well as their potential for including health education planning and intervention. A total of seven interactions were recorded comprising patient admissions and office and bedside handovers. In addition, background details of the nurses and patients involved were recorded for their relevance to subsequent data analysis.

A case study protocol was designed in order to facilitate and standardize data collection on the case study wards (see Appendix 5). This also consisted of items relating to factual details about the ward that needed to be collected by the researcher such as the number of beds and number and skill mix of staff. It also acted as an *aide-memoire*, outlining details of relevant data to be collected following each period of observation or recorded interaction. This process of standardization of the collection of supplementary information following each data collection period was also considered to have contributed to the reliability of observation and recorded interaction data.

Finally, the pilot study also involved the process of writing daily field notes following withdrawal from the ward. These comprised a combination of description of many informally observed events and conversations as well as interpretive notes about nurses' observed involvement in different types of health education practice and the influences involved in this. In addition, whilst the focus of the observation periods and the recorded interactions was at a health education level, the field notes provided an opportunity to document any evidence of nurses' involvement in health promotion type activities - that is, away from the bedside or the one: one nurse: patient level of interaction - that were either reported or observed.

### Revisions

To summarize, due to the extensive nature of the exploratory work preceding the pilot study, it was found that very few changes needed to be made in order to proceed with the main study. The methods of data collection were shown to be feasible and to elicit data relevant to the research aims and objectives. The only change considered necessary as a result of the pilot study was the method of distributing the questionnaires

such that for the main study the researcher attempted to approach each respondent personally in an effort to secure a more satisfactory response rate.

## The Main Study

### Sample and Access

Three case study wards were selected in order to collect data on the reality of nurses' health education and health promotion practice using a multi-method approach as developed in the pilot study. The researcher considered that three wards would provide sufficient data to allow a comparison of data collected from each setting. At the same time, it would enable the collection of in-depth data, thus allowing a comprehensive understanding of nurses' practice and the influential factors involved to emerge. The wards were selected from the sample of ward sisters interviewed using the following criteria: (i) geographical dispersion in different areas of the country (ii) a range of clinical specialities and (iii) in order to maximize the likelihood of observing health education and health promotion practice. In relation to the latter point, Yin (1991) considers that one of the characteristics of an exemplary case study is the selection of extreme or special cases for investigation. Thus it was considered appropriate to attempt to identify wards where the greatest development of health education and promotion work had taken place in order to more fully understand the way in which nurses' role was developing and the influential factors involved in this development. In case study research representativeness is sacrificed for the sake of a more complete understanding. A similar approach to sampling was adopted by Gott and O'Brien (1990) in their selection of locations for interviewing and observation of nurses' health education and promotion practice (see Chapter Two).

In an attempt to identify these areas of good practice, the interview transcripts were analyzed for evidence of a comprehensive range of health education and health promotion activities reported to be in operation together with an assessment of the ward sister's degree of insight into the meaning of the concepts and nurses' role. Those selected were independently reviewed by three other nurse researchers for evidence of the above criteria. In practice, these two criteria were related and, taking the other sampling criteria into consideration, the three wards emerged fairly readily.

Having selected the potential case study wards, the researcher re-established contact with the ward sister and relevant nurse manager to explain what involvement in this stage of the research would entail and to seek verbal consent to participate. As this

represented the consent of the ward sister only, an introductory meeting with the rest of the ward nursing staff was arranged to explain the nature of the project and what participation was likely to entail. A written summary outlining details of the project was given (see Appendix 6). Following each of the respective meetings, individual nurses' verbal consent to participate was sought. All of the nurses whom the researcher met agreed to co-operate with the proposed research. Letters informing individual medical consultants of the research were also sent. The approval of the respective District Research Ethics Committees had previously been granted simultaneous with the application for the interview stage of the project.

The final sample of wards consisted of a 28 bedded medical ward with oncology and diabetic specialities (Ward 1), a 20 bedded general medical ward (Ward 2) and a 28 bedded gynaecological surgery ward (Ward 3). Further details about these wards and the nurses working on them are given in Chapter Four.

### Ethical Issues

A number of ethical issues needed to be considered during the second phase of data collection on the case study wards. As in the interview phase, the first of these centred around the notion of informed consent to participate in the research. It was important that all nurses likely to be affected by the research being carried out on their wards gave individual informed consent for the study to proceed. Due to the possibility of the ward sister agreeing to participate on behalf of the nurses as a group, as described above, a meeting with all nursing staff likely to be involved was held on each ward in order to disseminate written (see Appendix 6) and verbal information about the project. Subsequently, individual nurses' permission was sought prior to each separate period of observation or audio-recording that was likely to involve them. Decisions to decline due to workload or for other reasons were respected.

The issue of informed patient consent also arose during the course of data collection on the case study wards in relation to both observation and audio-recording of nurses' interactions with them. All patients likely to be aware of the researcher's presence were given a written summary of the project (see Appendix 7). In addition, individual patients whom the researcher wished to observe or record were approached and given a verbal explanation prior to seeking their written informed consent to participate. Written informed consent was ascertained via a pre-formulated consent form designed for this purpose (see Appendix 8). It was recognised that a period of illness and hospital admission places patients in a particularly vulnerable position and that

obligation to participate in research may add further to any stress experienced. To this end, the researcher emphasized to each individual patient that they would not be required to do or say anything that would not ordinarily take place. In addition, both nurses and patients were given assurances that if an interaction were to become particularly sensitive or if either party were to experience undue distress, they would be free to request that the observation or recording be terminated. In practice, this situation did not arise, but the researcher remained sensitive to this possibility at all times. It was also considered important to give each individual sufficient time to ask questions and make a decision after having received appropriate information. This proved unproblematic in most cases, although when the researcher wished to record a patient admission the time available for this was somewhat compromised.

A second ethical consideration related to confidentiality of data collected from both nurses and patients. The permanency of the recorded data and the way in which anonymity and confidentiality were maintained has been described above in relation to the interview data. Codes were also added to the questionnaires administered to the ward-based nurses and the researcher's field notes referred to individual nurses and patients by codes as opposed to names.

The issue of confidentiality of the data collected also manifested itself in relation to a third area of ethical concern - the researcher's dilemma in the event of observing or recording "bad practice" on the case study wards. Essentially, respect for confidentiality needed to be balanced against judgements about what was in the best interests of patients and the public at large. The Code of Professional Conduct (UKCC 1993) requires that a nurse disclose information when it is in the public interest. The researcher was also faced with decisions regarding not only when to disclose information but also when to intervene in events being observed or recorded on the case study wards. Intervention in a situation in which the researcher was essentially an observer has implications for the reliability and validity of the data collected. To an extent, these dilemmas were a product of the investigator being both a nurse and a researcher. A number of authors have commented on this issue (e.g. Kratz 1978). As a nurse researching nursing, the researcher is more likely to be sensitive to omitted or bad practices and is also bound by a professional code of conduct relevant to the research situation in which he/she is involved. It was therefore necessary to give consideration to these issues prior to the commencement of data collection and to make decisions which would guide the researcher's actions. The researcher decided that in the event of observing practice which was deemed to have serious or life-threatening consequences, disclosure or intervention would take place.



These ethical concerns were highlighted prior to the commencement of data collection during the process of seeking approval for the research to proceed from the respective District Research Ethics Committees involved (see above). Fortunately, during the course of data collection, none of the potential dilemmas referred to above actually transpired, although on one occasion the researcher felt obliged to provide information to a patient in response to her request at the end of a period of observation. The action taken was subsequently shared with the relevant nurses involved.

### Data Collection Methods

In order to describe the reality of nurses' health education and promotion practice and the influential factors involved in this a number of data collection methods were employed on each of the case study wards. The researcher considered that in order to describe and understand a potentially complex phenomenon as it occurs in its natural setting, a single source of data would be insufficient. The methods employed were intended to be complementary to one another and these are described below.

#### a) Self-administered questionnaires and informal interviews

It was considered important to elicit the perspectives of those nurses working on the case study wards with regard to their role in health education and health promotion and the influences involved in the enactment of this. This would enable perceptions to be directly compared with the way in which practice was developing on these wards and allow an examination of the relationship between the two in a more direct way than was possible with the data on perceptions derived from the ward sister interviews alone.

The method chosen to ascertain data on nurses' perceptions of their role was via self-administered questionnaires. Some of the advantages of the use of questionnaires to collect data are that they are relatively easy to administer and analyze and they offer the respondent comparative ease of completion provided that the questions are clear and unambiguous. In view of the overall large number of nurses working on the case study wards (52 questionnaires were distributed in total), and the inevitable constraints on nurses' time during the course of a working day, these advantages offered by questionnaires were deemed relevant to the current study. Nevertheless, in comparison with interviews, questionnaires suffer a number of disadvantages. These are summarized by Polit and Hungler (1993) as:

a lower response rate

problems of misinterpretation

information of less depth is produced

The potential difficulties of a low response rate and misinterpretation were offset to a certain extent by the researcher's presence on the ward for a period of several weeks which enabled verbal reminders to be given to the nurses to complete and return questionnaires and facilitated clarification of any misinterpretation of questions. Whilst it was recognised that questionnaires could not provide the same depth of information as an interview, the level of detail produced was nevertheless considered sufficient for a supplementary database and in order to fulfil the purposes of the study. Additionally, the practicalities of interviewing all of the nurses working on each of the case study wards would have proved considerable. Rather, the data derived from the questionnaires was supplemented by interviews of an informal nature with selected respondents. These interviews took the form of conversations with some of the nurses individually, following observation of their practice. The conversations were focused around health education dialogues or activities that the nurse had been observed to be involved in and required her to reflect on any reasons why this development had been facilitated. Therefore, due to the lack of development of health education and promotion that was observed on two of the wards, only a small sample of nurses on the case study ward on which practice was most advanced were interviewed in this way (n=6). These conversations were tape-recorded and transcribed for later analysis. They provided data which offered further insight into the influences on the development of nurses' health education and promotion role from the perspective of the nurses themselves. Furthermore, insight was also generated through participating in and recording other conversations during the course of data collection on all of the wards. These were documented at the end of each day in the form of field notes (see below). Taken together, these sources were felt to provide a sufficient degree of insight into nurses' perceptions about their health education and health promotion role.

The questionnaire comprised open-ended items in order to allow the perspectives of the nurses' themselves to be explored and to enable a greater depth of information to be produced than would be possible with closed ended response items. The items included focused on: perceived role in health education and promotion as a nurse working in an acute ward setting and perceptions about the nurse's role in hospital health promotion policy. Respondents were also asked to indicate whether any factors influenced their health education and promotion practice. In addition, the questionnaire required the nurses to provide relevant personal details such as the length of time that

they had been qualified and their professional qualifications. This enabled both a profile of the nurses on each of the wards to be drawn up as well as making comparisons possible between personal characteristics and responses to the open-ended items.

The reliability of the questionnaires was also addressed during exploratory and pilot phases of the research. This helped to ensure that the questions were carefully worded and had clarity for the respondents. Other tests for reliability usually adopted for use with quantitative measures were not considered appropriate. For example, the split-half technique to assess internal consistency as a measure of reliability was inappropriate due to the small number of items included and the fact that a measure of quantification of responses was not possible. Similarly, the use of techniques such as the test-retest estimate of reliability were precluded by the qualitative nature of the data which did not permit the allocation of “scores” to responses.

#### b) Non-participant observation

Whilst the interview data derived from the first phase of the research and the questionnaire data described above would allow inferences about what nurses thought it was that they were doing in the name of health education and health promotion, observation of their practice provides the only direct means of examining this phenomenon. The use of observation in the current study has obvious relevance to the research aims and helped to overcome some of the distortions and inferences which may have resulted from the use of self-report measures alone. Previous research has been criticized for failing to include methods which directly capture nurses’ practice (see Chapter Two). In addition, the use of both observation and self-report methods in this study enabled comparisons between nurses’ perceptions and the reality of practice to be made.

When using observation as a research method, an important decision concerns the degree of concealment adopted for the purposes of making the observations and recordings. Gold (1958) describes the observer’s role according to a continuum ranging from complete observer to complete participant in the situation being observed. In this study, both of these were rejected as inappropriate: it was not possible to remain completely detached from nurses’ practice on the ward in order to document this without nurses’ awareness. This would also have introduced serious ethical issues for those involved. Nor was it possible for the researcher to adopt the role of complete participant in the research situation being described. This entails the researcher concealing her true identity from those being observed and thus again raises ethical

concerns. Also, due to the multi-method nature of data collection on the case study wards involving questionnaires and audio-recordings of nurse: patient interactions, the researcher's role was inevitably more one of observer than participant in the research setting. Thus, the role adopted was that of observer-as-participant (Gold 1958). More specifically, this involved informing the nurses and patients involved about the purposes of the observation and gaining their consent prior to each period of observation. The researcher then seated herself in a discrete position so as to cause minimal disruption to the natural characteristics of the setting under observation, whilst maintaining the ability to observe and record all aspects of nurses' interactions and activities with the patients. The reliability of observational data is inevitably influenced by the use of the human self as the method of recording data. Therefore it is influenced by the perceptions and cognitions of the researcher. Whilst these cannot be entirely eliminated, some checks were introduced. One of these, as indicated above, concerned the fact that care was taken over the position the researcher adopted for each two hour observation period such that activities and conversations could be recorded as reliably as possible whilst remaining unobtrusive.

A small group of four or five patients in close proximity to each other were selected for each observation period together with the one or two nurses that had been allocated to them for that shift. The pilot study (see above) showed that this generated sufficient activity for meaningful conclusions about what nurses were doing to be drawn whilst at the same time allowing the researcher time to record activities and interactions observed in sufficient detail.

The method of recording the observations followed an essentially unstructured format, in contrast to the use of pre-determined activity checklists or rating scales. The latter were considered inappropriate in view of the lack of previous investigation into hospital nurses' health education activity to guide the construction of a checklist or rating scale. This would also have imposed unnecessary constraints on the activities observed, rather than allowing an overall description of nurses' activities to emerge, including those that could be classified as health education. Polit and Hungler (1993) describe unstructured observational methods as those which generally involve the collection of large amounts of descriptive data that is analyzed qualitatively rather than quantitatively and where:

“The observer is guided by the research questions but is not constrained to observe only certain classes of phenomena or to systematically count the appearance of certain types of behaviours” (Polit and Hungler 1993: 207).

In accordance with this, descriptive notes were made about the types of activities and interactions that occurred during each two hour period of observation. These were later analyzed with a view to providing information about the interactions and the types of health education activities that nurses were developing on the case study wards. The observational data collected in this way served as a complementary data base to the more detailed information derived from audio-recordings of nurse: patient interactions (see below).

A number of disadvantages associated with the observational method have been identified. These include the fact that the very presence of the observer may distort the situation under observation thus affecting the validity of the recordings. Field and Morse (1985) suggest that one way of decreasing the effect is by spending a period of time in the situation before data collection starts so that the observer becomes sensitized to the situation and the informants have the opportunity to become used to the presence of the observer. To this end, a number of days were spent on each of the case study wards prior to the collection of any data via observation and audio-recordings. Whilst it is difficult to assess the effects of the observer's presence on the validity of the data the researcher's own impression was that the nurses quickly became accustomed to this. Their own comments to the researcher also suggested that this was the case - following a period of observation or a recording, some nurses said that they had forgotten that the researcher was there. This was perhaps due to the nature of the case study approach which requires a continuous and prolonged period of contact in order to understand the phenomenon under investigation.

Furthermore, with relevance to the validity of the observation data, Kerlinger (1973) points out that people do not do or say what they cannot or are unable to do. As an additional measure to enhance validity, any perceived observer effects were recorded in the field notes at the end of each day such that these could be taken into consideration in the analysis of the data (Blum 1952).

Deatrick and Faux (1991) also state that time sampling may threaten the credibility of observational data. They cite Deatrick's (1982) study as an example of qualitative research in which measures were taken to help overcome this. Deatrick interviewed adolescent patients and their parents about their perceptions of experiences which had occurred during the absence of the researcher. Patients' charts were also audited and team rounds were attended where staff shared patient information from all three shifts. Similar measures were also adopted in the current study due to the fact that the researcher could obviously not be present on the ward at all times. That is, the researcher was frequently present at the end of shift handover to ascertain information

about the health education activities of nurses. Relevant comments were recorded in the form of field notes and contributed to the researcher's overall impressions of the development of health education that had taken place on each of the case study wards. In addition, the sampling of the observation periods was designed to cover different times of the day, based in part on when the nurses reported that they were likely to engage in these activities. The interactions recorded by the nurses also provided a means of ascertaining data in the researcher's absence. Overall, it was felt that these measures helped overcome the threat to validity imposed by time sampling.

The potential problem of the reliability of the observational data was addressed not only through careful positioning (see above), but also through the use of a second researcher colleague familiar with the subject area. That is, reliability was assessed by this colleague simultaneously observing and recording data on two occasions during the course of main study data collection. Field and Morse (1985) suggest that standardized protocols necessary for establishing inter-rater reliability are generally inappropriate for participant observation as they are designed for use with structured observation instruments. The use of unstructured observation notes made this point pertinent to the current study. Therefore a correlation coefficient to give an estimate of reliability between the independent observers was not able to be computed. However, following the observation periods in which the two researchers recorded the same nurses' activities independently, the notes were compared for similarities and differences. The high agreement on both occasions suggested that the researcher's notes were a reliable means of recording data about what nurses were doing in interaction with patients on the case study wards.

### c) Audio-recordings

The central research objective of providing a description of nurses' health education practice on the case study wards necessitated the use of audio-recordings of nurse: patient interactions as a method of data collection. Given that many of the features that are believed to characterize successful or effective health education are rooted at the level of communication between the individuals involved, it was essential to record conversation data in this way. For example, in this way the degree to which the principle of two-way communication was enacted or the extent of patient participation in an interaction could be assessed. The presence or absence of other important health education principles such as the fostering of life-skills and self-esteem could also be analyzed through the detailed recordings of these interactions. Whilst to some extent this was possible through the analysis of observational data, the audio-recorded interactions permitted greater detail and depth of analysis. Research by Kratz (1975)

demonstrated that interactional data collected by observation and field notes alone did not provide the same depth or reliability of data as tape-recording could potentially provide. Exploratory work (see above) also indicated that this was the case and suggested that the interactional data could serve as an important complementary database to that derived from observation and field notes concerning nurses' health education practice. That is, whilst the observational data would allow a broad description of the interactions and types of activities that nurses were involved in to emerge, the recorded conversations would provide richer and more detailed material about the content and process of these activities and interactions.

Thus, recordings were made of various nurse: patient interactions on each of the case study wards including patient admissions, shift handovers and discharge advice sessions. The data collected in this manner were transcribed and analyzed with an emphasis on describing the types of health education activities that nurses were engaging in (which would enable findings from the observational data to be verified or otherwise). In addition, they were analyzed with a focus on the features or principles (such as patient participation and an individualized approach) which could potentially characterize any health education or other interaction between nurse and patient. The detailed procedure of conversation analysis, adopted for example by Kendall (1991) in her study of client participation in the health visitor: client interaction, was not considered appropriate to the aims of the current study. This was due to the fact that the interactions represented a supplementary database only, from which illuminative examples could be derived. The analysis was therefore essentially selective, focusing on the presence or absence of certain communication features pertinent to health education. In addition, as a method of interrogating the data, conversation analysis was considered beyond the scope of this study and is an approach which would warrant a separate investigation in order to fully exploit the method of analysis involved.

The advantages of audio-recording interactions centre around their capacity to provide accurate and reliable data that are permanently stored and which are not subject to inferences on the part of the observer in the way that other methods of recording may be. However, the validity and reliability of the data is dependent on both the quality of the recording equipment used and the degree to which the presence of the recorder disrupts the natural features of the interaction. The first issue was addressed through the purchase of a recorder which incorporated many of the characteristics which Field and Morse (1985) recommend for the purposes of data collection. These are: an in-built microphone with a good pick-up range of six feet from the source of

conversation, a recorder that signals the end of a side of the tape, the presence of a counter and the ability of the tape to be set at different speeds. Coupled with the fact that the researcher carried out regular checks on the batteries and carried new ones at all times, this enhanced the recorder's capacity to provide comprehensive and accurate data which reflected the reality of the encounter that had taken place. Distortions due to the presence of the recorder were minimized by the careful positioning of the equipment (and of the researcher herself) and the incorporation of the in-built microphone which made it unnecessary for the participants to wear attached microphones. In some instances, any potential distortion as a result of the researcher's presence was further reduced by the nurses themselves operating the tape-recorder in the absence of the researcher. This procedure was adopted either in response to a nurse's anxiety about the presence of a third party or due to the fact that an interaction that the nurse wished to record may have taken place whilst the researcher was absent from the ward. In either case, these recordings always followed detailed instructions in the use of the equipment by the researcher in order that the interaction was properly recorded and the reliability of the data maximized. A problem affecting the reliability of some of these recordings was found to be the level of background noise on the ward. For this reason, some interactions were not amenable to recording and in other instances selective transcription was necessary to accommodate this. It is recognised that this compromises the reliability and validity of the audio-recorded data to some extent.

#### d) Field notes

The process of collecting data on the case study wards also involved writing field notes on a daily basis following withdrawal from the ward setting. The use of field notes as a data collection tool was considered valuable as an adjunct to the other data collection methods employed. As the purpose of data collection and analysis is to enable the researcher to understand the phenomenon under study, the first step is to make sense of the setting or context in which the phenomena are occurring. The use of field notes provides the researcher with both a data gathering and analytical tool to assist with this task (Field and Morse 1985). Although field notes are generally considered as part of the process of participant observation where they form a primary means of recording data, they were nevertheless seen to provide an important complementary database in this study. Bogdan and Biklen (1982) define field notes as:

“a written account of the things the researcher hears, sees, experiences and thinks in the course of collecting or reflecting on data in a qualitative study”  
(Bogdan and Biklen 1982, cited in Field and Morse 1992: 79).



This definition makes clear that field notes comprise both a documentary and an analytical element - or, as Field and Morse (op. cit.) suggest, both a “data gathering” and an “analytical tool”. Thus, during case study ward data collection, field notes were used as a vehicle for gathering data about many informally observed events and conversations witnessed during the course of each day’s data collection. Details about the context of interactions which were audio-recorded also formed part of the field notes and this was felt to enhance the recordings and provided material relevant to later analysis of the recordings. In addition, the field notes provided the researcher with the opportunity to record thoughts about the development of health education and promotion on each ward and the influential factors involved in this. Information gathered about nurses’ involvement in any health promotion, as opposed to health education, type activities was also recorded in the field notes. As data collection proceeded this process was influenced by the researcher’s prior experience on the preceding case study wards, i.e. some comparison between wards was possible and proved useful in attempting to identify the explanatory influences on practice.

The method of recording field notes began with the researcher jotting down salient points to act as an *aide memoire* which could then be reworked in detail later the same day. These points covered a wide range of experiences considered pertinent to nurses’ health education and promotion practice. For example, conversations between nurses or between the nurses and the researcher, or an interaction between a nurse and a patient or other health care professional. An obvious disadvantage of the use of field notes as a method of recording data is that they are subject to loss or distortion due to memory. Field and Morse (1985) suggest that there are some critical points to follow in order to minimize loss of data in this way. These include: getting right to the task; not talking about the observation before it is recorded; finding a quiet place to write; setting aside adequate time to complete the notes; sequencing the events in the order that they occurred and letting the events and conversation flow from the mind onto the paper. Thus, the researcher attempted to fulfil all of these criteria by withdrawing from the ward at the end of each day to a library or quiet room in order to write detailed notes from the key points made during the course of the day. Where possible, two to three hours were allowed for this process in order to minimize loss of data and enhance the comprehensiveness and depth of the field notes.

The field notes served as a useful complementary data base to the other data collection methods employed on the case study wards. They were used to identify both the types of activities that nurses were engaging in on each of the respective wards and the explanatory influences involved from the researcher’s perspective.

In summary, a number of different methods were employed on the case study wards in order to capture nurses' practice of health education and promotion in the acute care setting. It was intended that these were complementary and that they would allow a comprehensive picture of nurses' practice on each of the wards to emerge.

### Data Collection Procedure

The main study data collection began on Ward 1 in Autumn 1991 and the researcher spent a period of four weeks on the ward, by which time data collection was considered to be complete. Data collection on Ward 2 commenced in November 1991 and again involved the researcher spending a period of four weeks on the ward. A similar period of time was spent on Ward 3, with data collection commencing in December 1991 and ceasing in January 1992. In accordance with Yin's (1991) assertion that good case study research is characterized by a lack of time and resource constraints, it was considered necessary to spend as much time as was necessary to enable a picture of practice to emerge on each ward. Thus, no pre-conceived time limits were imposed on the period of data collection. Rather, after four weeks on each ward, the researcher considered that a sufficient understanding of nurses' health education and promotion practice and the influential factors involved had emerged and no "new" data were forthcoming.

The methods of data collection were those described above. Following a familiarization period on the ward when no data were collected, the qualified staff and senior student nurses were given a questionnaire with a personal introduction by the researcher. The pilot study had suggested that this was important in producing a satisfactory response rate. The number of questionnaires returned suggests that this may have had the desired effect: Figure 1 shows response rates of 52% (n=12), 70% (n=14) and 78% (n=7) on Wards 1, 2 and 3 respectively were achieved following a reminder to those who had not returned questionnaires after a period of two weeks.

Patients were selected for observation on the basis of the likely possibility that nurses would engage in some type of health education with them during the period of observation. For example, there was little point in focusing on a group of patients who were heavily sedated in the immediate post-operative period. Similarly, some patients were off the ward for lengthy periods of time undergoing investigative procedures. (For further details of sampling see Appendix 5). The nurses likely to be involved in caring for the selected patients were approached and their permission sought for the

observation period to proceed. The patients were then approached and given a written and verbal explanation about the project and what the proposed period of observation would entail. Informed written consent was gained from all patients approached in this way and no objections to being observed were expressed. The total number of completed observation periods for each ward is shown in Figure 1. This shows that eight periods were completed on Ward 1, nine periods on Ward 2, and eight periods on Ward 3.

The audio-recorded interactions were selected on the basis of their potential for representing opportunities for nurses to plan for or engage in health education with patients. (For further details of sampling see Appendix 5). Informal conversations with nurses on the wards led to the identification of specific incidents such as the admission of a patient and discharge advice. In other instances, the nurses themselves indicated when they were about to engage in health education with patients and invited the researcher to record the interaction. This led to the audio-recording of interactions such as advice about medication. It is recognised that this method of sampling necessarily led to a focus on pre-specified or isolated events as opposed to health education interactions which were integral to other nursing activities. However, it was hoped that this difficulty was overcome by the complementary method of non-participant observation of nursing activity which would allow the latter type of interactions to be observed and recorded. Preliminary observation on two of the three wards also indicated that, in general, health education activities were not integrated into nurses' practice, suggesting that little was missed by focusing on pre-specified events and interactions in this way.

As can be seen in Figure 1, seven interactions were recorded on Ward 1, nine on Ward 2 and eleven on Ward 3. The total number varied according to the type of events which were normally a feature of practice on each ward. For example, there was no admission event as such on Ward 2, and Ward 3 was the only ward to have introduced a regular group discharge advice session. In addition, the variance is accounted for by the researcher's judgement as to when sufficient data had been collected that would allow the research aims and objectives to be fulfilled.

During the course of data collection on Ward 2, it became apparent that some development of health education activities had occurred. Thus, in an attempt to gain insight into the influences involved in this, individual nurses were informally interviewed following a period of observation. These post-observation interviews were tape-recorded with the nurse's prior consent (see above).

During the period of data collection on each ward, the case study ward protocol (see Appendix 5) was utilized to standardize data collection and recording and also to collect relevant details about various aspects of the ward itself and the nursing staff. This involved a combination of observation of relevant details, ascertaining information from the nurses and making use of written records and documentation. These data were collected at times of convenience for both the nurses and the researcher throughout the four week period spent on each ward.

Finally, field notes were made daily as described above. These were written out long-hand by the researcher following withdrawal from the ward at the end of a period of data collection.

### Problems with Case Study Ward Data Collection

The main problem with data collection on the case study wards concerned the audio-recordings of nurse: patient interactions. Despite the technology of the recording equipment and the high quality of the in-built microphone used, the nature of the interactions and the ward environment made the transcription of some of the recordings difficult. More specifically, interactions involving a number of different participants meant that on occasions it was difficult to attribute certain comments to identifiable individuals. This occurred for example during the bedside handovers and some of the group discharge advice sessions. In other instances, more than one interaction was being carried out simultaneously and / or the level of background noise was sufficiently high to preclude an accurate transcription subsequently. Whilst the researcher became aware of this during the course of data collection, and attempts were made to minimize it (through the careful positioning of the microphone and its proximity to the participants), the problem could not be entirely eliminated. This was therefore influential in the decision to selectively transcribe some portions of the audio- tapes and it is acknowledged that some of the data may have been lost through this. Nevertheless, the tapes were played back and listened to at the end of each day's data collection and, with this awareness of the quality of the data recorded, the researcher was able to decide when sufficient good quality data had been recorded such that a picture of nurses' practice had emerged and data collection could cease.

To an extent, the problem of multiple interactions also affected the recordings made during periods of non-participant observation. Due to the limitations of the human senses, the researcher was only able to focus on one interaction at any point in time, particularly when detailed verbatim notes about an interaction were being attempted.

Decisions about which interaction to focus on were made with reference to continuity, that is, the researcher continued to record the same interaction or activity rather than switch to one beginning subsequently by another nurse or patient. Consideration was also given to the content of the interaction or activity in terms of its relevance to health education. Whilst it is recognised that some data could be considered to have been lost in this way, it would not have been possible and it was not the intention to record every activity or interaction on the ward. At the end of the period of data collection, the researcher considered that sufficient data had been collected through this method of observation to allow the major activities that nurses were involved in to be described.

### Analysis of the Case Study Ward Data

Each type of data provided a different emphasis or insight into the central research objectives of describing the way in which nurses were developing their health education and promotion role at ward level and the influential factors involved in this. Therefore each data set required a different method of analysis congruent with the insight offered. The process of data analysis also incorporated triangulation of the data sources from individual wards in order to substantiate and validate findings emerging from a single source. Whilst the technique of triangulation has been considered elsewhere, the specific method of analysis for each data set is described below.

#### a) Questionnaire data

The biographical or personal details of staff completing questionnaires were transferred to a coding sheet and entered onto an Apple Macintosh personal computer before being analyzed using the Minitab software package. Descriptive statistics of the staff characteristics on each ward were produced and it was possible to highlight differences between wards with respect to some variables of interest.

Responses to the open-ended items on perceptions of the nurse's role in health education and health promotion were analyzed using a process of content analysis. This enabled the identification of the major categories emerging and the data were then subjected manually to a form of quantitative analysis in order to give an indication of the frequency or prevalence amongst the sample of the categories that emerged. This process has been described in detail elsewhere in this Chapter.

#### b) Non-participant observation data

The aim of utilizing non-participant observation as a data collection tool was to enable the researcher to provide an overall description of the types of activities and interactions that nurses were engaged in, including those of a health education nature. Unequivocal

statements could not be made on the basis of the observation notes alone - for example, explanatory influences on nurse' practice cannot be derived from them. However, it was hoped that the data would allow some general statements about nurses' practice to be made and they were intended to serve as a complementary data base to the other forms of data collection employed. To this end, the data were analyzed using a form of activity analysis. No prior framework was applied to the observation data - rather the intention was that the activities would emerge from the notes themselves. The notes derived from observation of nurses' practice were analyzed separately for each ward. Each set of notes were studied with the following questions in mind: what were the nurses doing? what types of health education activities and interactions were they engaged in? In this way a pattern of common forms of activity pertinent to each ward began to emerge. For example, it was apparent from the observation notes that on Ward 1 there were sometimes extensive periods of no nurse: patient interactions and the majority of interactions were apparently based on the nurse's need to carry out physical care with or for the patient. The only activity documented which bore any relationship to health education was that of giving information in the form of a commentary on what the nurse was about to do, such as lift or turn the patient. Key notes were made about the activities observed in a margin designed for this purpose (see Appendix 4). Following this, these key notes were reviewed as a whole for each ward to determine the major forms of activity or interaction that had been observed during the data collection period. This process revealed that similar activities characterized each observation period on the respective wards largely irrespective of the timing of the observation period or the nurses involved. This therefore lends reliability to the data collected. Reliability and validity was also addressed by sharing a sample of the observation notes from one of the wards with a group of post-graduate researchers for their comments on the types of activities documented during observation periods. A group discussion revealed that the types of activity and interactions identified were very similar to those previously identified by the researcher.

#### c) Audio-recorded data

Two types of recordings were available for analysis: the majority comprised nurse: patient interactions during selected ward events such as patient admissions and nursing bedside handover on each of the wards. A smaller database of informal interviews with nurses on Ward 2 who were asked to describe the influences on their health education practice was also available.

Due to the total number of the interactions recorded and the fact that they were intended as a complementary rather than a main database, a detailed conversation analysis

approach was rejected as inappropriate (see above). This decision was reinforced when the researcher listened to many of the recordings made. As discussed above, the nature of a number of the recordings was such that it was impossible to identify individual contributions to an interaction. This therefore precluded a conversational analysis approach which requires a micro-analysis of the contribution of each of the participants. Instead, the procedure adopted began with the researcher attempting to become familiar with the content of each of the interactions. Thus, each tape was played back and listened to several times and notes made about the overall content of the interaction with specific attention to its ability to illuminate the way in which health education was being enacted by nurses in the ward setting. Following this, the tapes were selectively transcribed with reference to their audibility and their relevance to the research objectives. Subsequently, more detailed notes were made about each transcription in relation to (i) the types of health education activity recorded - for example information giving, encouraging patient participation in care, advice on lifestyles (ii) the approach taken to the interaction with the patient - for example, whether it was nurse-dominated or in collaboration with the patient and (iii) opportunities to engage in a form of health education that were taken or apparently missed by the nurse were also noted. Finally, an overview of these notes provided the researcher with an understanding of the most common findings pertinent to each ward.

The reliability of this process was checked by having another researcher with expert knowledge of the subject area carry out the analysis on a sample of the transcripts. Although it was not possible to quantify the percentage agreement between the researchers, remarkably similar conclusions were drawn about what the transcripts indicated about nurses' health education practice. The illuminative examples of dialogue chosen to illustrate findings were also almost identical between the researchers. In addition, a further sample of transcripts were shared within a forum of post-graduate researchers. Their verbal comments indicated an overall level of agreement with the findings emerging as a result of the researcher's own prior analysis.

The smaller database of informal interviews with nurses on Ward 2 were all transcribed in full and analyzed using a process of content analysis with a view to illuminate the nurses' perceptions about the reasons for the development of their health education practice.

#### d) Field notes data

The field notes made by the researcher were of primary interest for the insight that they could offer into the factors, from the researcher's perspective, that helped explain the

way in which nurses' health education and promotion practice had developed. Through the documentation of many events and conversations observed by the researcher which were not formally recorded, they could also be used to lend validity to the findings derived from the other sources of data collection concerning the types of activities being developed. In addition, it was also hoped that the field notes would allow for any evidence of nurses' involvement in health promotion type activities to emerge. Whilst the focus of the recorded interactions and the non-participant observation was on health education at the individual nurse: patient level, the researcher could have recorded any direct or indirect evidence of, for example, involvement in health promotion policy or inter-sectoral collaboration in the field notes.

Thus the field notes were analyzed with a specific focus on: (i) entries related to perceived influences on practice (ii) entries which described an activity characterized by features of health education (iii) entries pertaining to evidence of nurses' involvement in health promotion type activities. Following this, the categories derived were reviewed as a whole for each ward in order that overall conclusions about the major features of the field notes could be arrived at.

In summary, the method of analysis applied was eclectic, combining different approaches in order to reflect both the variety of data sources and the potential insight that each could offer in relation to the case study aims and objectives. A detailed description of the findings resulting from this analysis, can be found in Chapter Five. The findings from the interview phase of data collection follows in Chapter Four.



## **CHAPTER FOUR**

### **FINDINGS FROM PHASE ONE - NURSES' PERCEPTIONS.**

This Chapter addresses the findings pertaining to nurses' perceptions of the concepts of health education and health promotion and nurses' practice and role in this in acute care settings. Findings from a content analysis of data derived from semi-structured interviews, as described in Chapter Three, are presented below.

#### **Characteristics of the Ward Sisters**

A total of 132 ward sisters were interviewed in nine DHAs. Table 1 shows the number of respondents within each DHA. The disparate numbers are explained by the variation in the total number of acute wards between Districts and the sampling design, which necessitated a 50 % sample of wards from each DHA to be included (see Chapter Three).

**Table 1: Number of interviews completed in each DHA**

| <b>District Health Authority</b> | <b>Number of interviews</b> |
|----------------------------------|-----------------------------|
|                                  |                             |
| 1                                | n=7 (5%)                    |
| 2                                | n=30 (23%)                  |
| 3                                | n=12 (10%)                  |
| 4                                | n=7 (5%)                    |
| 5                                | n=6 (4%)                    |
| 6                                | n=20 (15%)                  |
| 7                                | n=15 (11%)                  |
| 8                                | n=22 (17%)                  |
| 9                                | n=13 (10%)                  |

Of those originally sampled, according to the criteria outlined in Chapter Three, 8 % (n=10) of ward sisters were unwilling or unable to participate in an interview. Time permitting, additional ward sisters were recruited to the study following the recommendation of nurse managers and/or other personnel in order to achieve a 50% sample in each DHA.

The majority of interviews were tape-recorded (95%, n=126) and lasted an average of 45 minutes, with a range of 20 minutes to one hour and 45 minutes. Two per cent (n=3) of ward sisters declined to be tape-recorded, and in three instances, mechanical failure of

equipment was responsible for failure to record the interview. The methods employed by the researcher to minimize the loss of potentially important data as a consequence have been described in Chapter Three. In addition, telephone interviews were conducted with 2 ward sisters who were unavailable at the time the researchers visited their respective DHAs, and who expressed a strong desire to participate.

The sampling design resulted in interviews with ward sisters on predominantly 4 types of ward, as shown in Table 2. Just over a third of interviews (36%, n=48) took place on specialized surgical wards, the majority being gynaecology, orthopaedic and ear, nose and throat surgery wards. General medical and general surgical wards constituted 24% (n=32) and 18% (n=24) of the sample respectively. Interviews on specialized medical wards included haematology, cardiology and rheumatology wards. (14%, n=18.) 'Other' wards comprised 8% (n=11) of the sample and these included, for example, specialized regional units and wards on which a combination of medicine and surgery was practised. The sample wards could therefore be considered a representative cross-section of the major types of acute ward found within a District General hospital. Although the specialized nature of some wards could be expected to influence ward sisters' responses regarding , for example, the types of health education and health promotion activities nurses were engaged in, in reality the findings were similar irrespective of ward type. However, some responses were peculiar to the surgical nature of some of the wards (see below).

**Table 2: Types of ward comprising ward sister interview sample**

| Type of ward         | Number of interviews |
|----------------------|----------------------|
|                      |                      |
| Specialized surgical | n=47 (36%)           |
| General medical      | n=32 (24%)           |
| General surgical     | n=24 (18%)           |
| Specialized medicine | n=18 (14%)           |
| Other                | n=11 (8%)            |
|                      |                      |

A number of details about each individual ward sister were collected for their potential relevance to perceptions of health education and health promotion practice: these were coded and analyzed using the Minitab statistical package.

Respondents were asked about the length of time they had been qualified. Table 3 shows that those most recently qualified had done so 3-4 years ago. None had completed their training less than 3 years ago; given the seniority of the position of ward sister, this finding is hardly surprising. Nearly half of the sample (46% n=61) had been qualified over 10 years, with a large proportion of these (25%, n=33) having completed their training more than 20 years ago.

**Table 3: Ward sisters' years since initial qualification**

| <b>Length of time</b> | <b>Number of ward sisters</b> |
|-----------------------|-------------------------------|
|                       |                               |
| 0-1 year              | 0                             |
| 1-2 years             | 0                             |
| 2-3 years             | 0                             |
| 3-4 years             | n=8 (6%)                      |
| 4-6 years             | n=17 (13%)                    |
| 6-8 years             | n=18 (14%)                    |
| 8-10 years            | n=28 (21%)                    |
| 10-15 years           | n=16 (12%)                    |
| 15-20 years           | n=12 (9%)                     |
| 20+ years             | n=33 (25%)                    |
|                       |                               |

Ward sisters were also asked about their nursing and any other qualifications obtained, either pre- or post-registration. Recordable qualifications or courses, as well as those which may have had a potential influence on health education and health practice, were coded and analyzed. Table 4 shows that over two thirds (70%, n=93) had taken at least one English National Board for Nursing (ENB) accredited course and that over half (51%, n=67) had obtained the ENB 998 course, Teaching and Assessing in Clinical Practice. A smaller proportion (14%, n=19) had obtained the City and Guilds 730 – Further and Adult Education Teacher's Certificate.

**Table 4: Ward sisters' additional qualifications**

| <b>Qualification</b>   | <b>Number of ward sisters</b> |
|------------------------|-------------------------------|
|                        |                               |
| Nursing Degree         | n=3 (2%)                      |
| Other Degree           | n=4 (3%)                      |
| Nursing Diploma        | n=20 (15%)                    |
| ENB course             | n=93 (70%)                    |
| ENB 998 course         | n=67 (51%)                    |
| City and Guilds 730    | n=9 (14%)                     |
| Relevant other courses | n=11 (8%)                     |
| Other courses          | n=67 (51%)                    |

Only a small number of ward sisters had obtained Bachelors or Masters degrees (5% n=7), and of these only 2% (n=3) were in Nursing; the Nursing Diploma was a more common qualification, with 15% (n=20) of the sample having undertaken this. Eight per cent (n=11) of the sample had taken a course which was thought relevant to health education and health promotion practice ("Relevant other"); these included the Health Education Certificate and Look After Yourself courses. "Other courses" refers to a diverse range mentioned by ward sisters which are not recordable or nationally recognizable – for example, locally run courses on first-line management or staff development courses.

#### **Ward Sisters' Perceptions of Health Education and Health Promotion**

Data pertaining to the way in which ward sisters interpreted the concepts of health education and health promotion were derived from a number of different items included in the interview schedule. Findings from questions that indirectly shed light on ward sisters' understandings of what constitutes health education and health promotion are presented in subsequent sections of this Chapter.

Data were collected via a direct question at the outset of the interview on meanings ascribed to these concepts. Ward sisters were asked (i) what they understood by the terms 'health education' and 'health promotion' and (ii) to clarify whether they perceived a difference between them, and to elaborate on any distinction made. It is worth noting that this item did not ask respondents for their interpretation of the concepts in relation to their role or work as nurses. Rather, the question allowed for broad and comprehensive data on understandings and principles to emerge, without

restricting interpretations to the way in which they articulated with their role as nurses, a point returned to later.

### Meaning Applied to the Concepts of Health Education and Health Promotion

This question ((i) above) elicited a wide range of diverse responses. Despite the diversity of meanings attributed to these concepts, analysis revealed a number of common underlying themes. Responses were analyzed using a process of content analysis to produce inductively derived themes illuminating ward sister's understandings. Initial analysis of the data pertaining to part (i) of this question, meanings ascribed to health education and health promotion, revealed that the emergent themes did not relate specifically or consistently to one concept or the other. Rather, themes that emerged in relation to understandings of 'health education' were also apparent in relation to interpretations of 'health promotion' and vice versa. This suggests that, prior to being asked about distinctions between these two concepts, the majority of ward sisters expressed ideas indicating that they did not distinguish health education from health promotion in any well-defined way. It was therefore decided to analyze responses to both concepts in combination in this part of this question.

Analysis revealed that responses fell into three main categories:

- (a) responses about the content or subject areas covered by health education and health promotion;
- (b) responses relating to the aims or outcomes of health education and health promotion, and
- (c) responses about the method of delivery or activities associated with health education and health promotion.

These categories are linked, and it was possible for a respondent to mention either only one or all of these categories in a single response. However, they are presented and discussed separately below for the sake of clarity.

#### (a) Responses related to the content of health education/health promotion

Ward sisters generally perceived that the content or subject matter of health education or health promotion consisted of information about either (i) lifestyle or personal habits, or (ii) illness and coping with illness.

Many ward sisters (48% n=63) appeared to regard health education/health promotion as a means of addressing a person's lifestyle or health-related habits. For example, one ward sister commented that:

*"Health education really means trying to educate people into a healthier lifestyle."*

And another's was typical of this idea:

*"Health education is making people aware of what they should be doing, perhaps suggesting ways of changing their lifestyle."*

More specifically, this lifestyle advice was most commonly perceived to revolve around issues of diet and smoking, as the following comments illustrate:

*"Health promotion means saying to the patients before they go home about smoking, eating a healthy diet and anti-stress techniques."*

*"Health promotion . . . . I think of it as diet . . . . to be very aware of what people are eating, what they are doing with their bodies, really."*

*"Health education – I see it as closely linked to health promotion . . . . we try to discourage people from smoking and make them aware of losing weight if they need to lose weight, and eating healthily."*

Not only were a broader range of lifestyle issues, such as alcohol intake and stress, absent from the ward sisters' responses, but also lacking from the data was a recognition of the complexity of factors which interplay in personal lifestyle choices and decisions. Thus, no mention was made by any of these ward sisters of the relationship of wider, structural social and economic influences on individual's lifestyles and health related habits.

The other broad theme that emerged in relation to ward sisters' interpretations of the subject areas relevant to health education and health promotion was that of giving information about existing illness and/or coping with that illness. This idea was reflected in 38% (n=50) of the responses. This finding suggests that respondents were focusing on the tertiary as opposed to the primary and secondary prevention aspects of

the concepts. Many responses reflected this 'illness-orientation' – a sample are quoted below:

*"Health education would be, well, the conditions we nurse, like diabetics, asthmatics. And with diabetics you've also got, apart from the diet, their healthy living, small things like chiropody and eyes."*

*"Health education is . . . . how you put over to people the treatments and the diagnosis and helping them, in general, how to look after themselves."*

*"Health education, to me, means instructing, giving information – for example, for a patient going for a hysterectomy, you would educate them as to what to expect, what will happen – that's how I see education."*

In this respect, responses referred to education or advice about illness or disease as the legitimate subject matter of health education/health promotion. There was little emphasis on the giving of information about the promotion of health and well being *per se*, that is, as distinct from notions of illness. Whilst this is not surprising, given the nature of the environment in which these ward sisters were working, it suggests that their interpretations are influenced and limited by the illness-orientated ward environment in which they work as opposed to a more comprehensive understanding of the fundamental principles involved, unconstrained by situational factors. This point is returned to in Chapter Six. The above excerpts also illustrate a further characteristic of the ward sisters' interpretations: an orientation to physical health and disease to the exclusion of social and mental facets. Whilst some responses did reflect evidence of health education and health promotion consisting of information about psychological or mental health, this was generally only in relation to a physical health problem, as the latter comment (above) about a hysterectomy patient illustrates. Information relating to psychological or mental and social health in its own right did not appear to be considered legitimate subject matter for health education and health promotion.

In addition, in comparison to the potential scope for types of health education information (as outlined in Chapter One) the ward sisters' responses appear to be quite limited. Whilst 4% (n=5) considered that health education/ promotion could be about "screening", more generally there was a lack of reference to other preventative services forming part of the content of the message. In addition, none mentioned education about the social and economic determinants of health or ideas which would equate with

what Tones et al. (1990) refer to as “agenda setting” as part of the content of a health education message.

(b) Responses related to the aims of health education and health promotion

A second group of responses reflecting ward sisters’ understandings of the nature of health education and health promotion was related to the aims or intended outcomes of health education and health promotion activities. Quite clearly, these were linked to their ideas about the content of health education and health promotion (above).

Unsurprisingly, a number of respondents (22% n=29) mentioned the prevention of illness as the goal of health education and health promotion activities, as the following illustrate:

*“The terms health education and health promotion equate in my mind with the goal of prevention.”*

*“I think it’s informing the patient of what – um – a way of life which might prevent them – um – becoming ill in the future.”*

*“It’s information-sharing with people about how they can prevent other factors affecting their health.”*

In some instances there was a recognition that preventing illness was not the only aim: that is, some of these comments reflected a belief that the promotion of good health was also an objective of health education and health promotion. This duality is apparent in the following statements from ward sisters:

*“I see it as educating people, clients, patients – whatever – to prevent illness and promote a healthy person.”*

*“It’s giving information and explaining how to improve health and stay healthy and keep them free from disease.”*

*“Health education is a way of promoting health and restoring people’s health.”*

Such comments are indicative of a recognition of the overlap or inseparability of the goals of promotion of health on the one hand, and the prevention of disease on the other.



In addition, several ward sisters cited coping with or adjusting to illness as an intended outcome of a health education or health promotion activity. This clearly relates to what ward sisters' perceived to be the appropriate content of health education or health promotion (above). The following responses encapsulate this idea:

*"I suppose . . . . most of the patients have ongoing illnesses really, like diabetes and heart failure, and so it's aiming to help them to come to some acceptance of that, of their ongoing conditions."*

*"It's more to do with the stage patients are at the moment, and the education and coping with their lives as they are, rather than preventative."*

*"If I talk about health education, I tend to be talking about people who are ill, who need to understand their illness, or either adapt their lifestyle or live within their limitations."*

*"Health education would be making sure that when people went home they could carry out any treatments they needed to do and to make sure they were fully warned of what not to do and why, and how they could help themselves regarding a specific condition."*

In this sense perceptions about the aims of health education and health promotion are once again linked to the idea of tertiary prevention, as opposed to health education and health promotion aimed at primary and secondary prevention. The ward sisters' focus is on illness as opposed to health and well being in its own right. Such interpretations are also likely to be a reflection of these nurses' work situation, that is, they are hospital-based and therefore dealing with individuals who are ill. However, as previously mentioned, this question did not require the ward sisters to confine their responses to those pertinent to their current work situation.

Finally, in relation to the aims of health education and health promotion, a minority (11% n= 14) of ward sisters considered that inherent in a health education or health promotion approach is the desire to maximise a patient or individual's self-responsibility for his/her health and lifestyle. This was reflected in a number of comments emphasizing the importance of outcomes such as promotion of self-care abilities, informed choice, control over and individual responsibility for health action. Examples include:

*"Health education is enabling or facilitating self-care because of a health problem."*

*"I suppose, really, I'd say (it's) giving information in the broadest sense to patients so they can take more control of their own lives and make informed choices."*

*"Health education is about teaching from the beginning of life . . . . for someone to feel responsible that if they are going to drink, then they don't drive."*

*"Health education is perhaps – um – if you're educating people, you're giving them the information to make informed decisions themselves."*

However, responses lacked reference to barriers to informed choice (such as social and economic constraints) and/or broader aims such as stimulating individuals to consider wider structural influences on their health and how they may go about addressing these (identified as critical consciousness raising by Tones et al. 1990). As outlined in Chapter One, the aim of enabling people to take control and to make informed choices depends on more than the giving of information alone. In addition, the idea of individual responsibility for health has been criticized in that it is unethical to promote this in the absence of other mechanisms which enable this to happen. Thus, although a minority of respondents appeared cognisant of such ideas as informed choice and self-responsibility, it seems that perceptions about the complexity of these concepts are limited. In addition, none of the ward sisters linked these ideas to the goal of empowerment.

Reference to aims at the broader level at which health promotion operates were also lacking from the ward sisters' responses. None of the respondents mentioned the implementation of health promoting policies at a hospital or wider societal level, or the creation of supportive environments for health, outlined as key principles of health promotion by the World Health Organization (1986b) (see Chapter One). The data therefore indicate that the ward sisters' understandings of the aims of health education and health promotion and health-related changes that could be expected or hoped for, were rooted at an individual, as opposed to a wider structural or policy level.

**(c) Methods of delivering health education and health promotion**

A third category emerging from the data concerned ward sisters' ideas about what particular methods or activities comprised legitimate health education or health

promotion work. In keeping with the findings described above, when ward sisters did describe a method of delivering health education or promotion, they commonly perceived that this takes place at the one-to-one, nurse: patient level. Generally, appropriate methods were interpreted largely as consisting of advising, informing and educating individuals or patients. Fifty five per cent (n=73) of the ward sisters made reference to these methods of delivering health education. The following comments reflect this theme:

*“Health promotion is a system of giving health information – it’s information-giving.”*

*“Health education is educating the patients, giving them the knowledge to be able to look after themselves when discharged.”*

*“Health education conjures ideas about advising, sharing information with individuals in relation to healthy options and disease processes.”*

Such comments reinforce the idea that these ward sisters’ perceptions were located at the health education level, as opposed to the policy level at which health promotion operates. However, data analysis revealed that responses lacked evidence of a recognition of some of the key principles that are currently believed to constitute an effective approach to health education at the one level. For example, none of the ward sisters referred to the two-way, participatory or empowerment aspect of information and advice-giving which is widely regarded as an essential element of health education at a one : one level (see Chapter One). In addition, analysis of the data indicated that perceptions were confined to educational activity with patients - no mention was made by the ward sisters of the education of key policy makers and health and other professionals as important constituents of health education. The latter activity is highlighted as important by both Tones et al. (1990) and Downie et al.(1991), as outlined in Chapter One.

There was also a lack of referral to the policy element of health promotion - only one ward sister mentioned health promoting policy planning and formulation in her response to this question:

*“Health promotion is encouraging people to make healthy choices by, for example, making the ward a no-smoking area and encouraging healthy eating by menu options, for example, having wholemeal bread available.”*

In addition, analysis showed that activities such as inter-sectoral, collaborative working with other professional or lay groups as well as lobbying, advocacy or mediation were not mentioned by respondents, indicating that they did not form a part of their interpretation of the activities comprising health education and health promotion. To summarize, analysis of responses to a question asking respondents to describe what the terms health education and health promotion meant to them revealed a number of related findings. The ward sisters did not spontaneously distinguish between the two terms, and therefore responses were analyzed as a whole. Analysis indicated that responses could be organized according to whether they described the content, aims or method of delivering health education or health promotion. However, recurring ideas were found to underlie all of these categories. That is, there was an emphasis on illness as opposed to the promotion of positive health and physical facets of health and disease to the exclusion of mental and social components. In comparison to the potential scope of health education information (as outlined in Chapter One) the ward sisters' perceptions were limited and lacking in complexity. Responses were characterized by a focus on individuals and their lifestyles and lacked reference to the wider, structural influences on health and policy measures designed to make the latter more health enhancing. Recognition of other important principles were also absent, such as the essential two-way, participatory nature of the education process and the aim of empowering individuals as part of the process or outcome of health education. Together the findings suggest that the ward sisters are operating with ideologies which equate to the more traditional or simplistic paradigms described in the health education and health promotion literature. This finding is confirmed and returned to repeatedly throughout the course of this Chapter and is discussed further in Chapter Six.

### Distinctions Between Health Education and Health Promotion

Respondents were also asked whether they perceived a difference between the terms 'health education' and 'health promotion' and to clarify any perceived difference. This allowed further exploration of ward sisters' understanding of these concepts.

Nearly three quarters of the sample (73%, n=96) felt that there was a difference, whilst the remainder (25%, n=33) stated that they would use the terms interchangeably to mean one and the same thing. (Three respondents (2%) gave responses which were unclear as to whether a distinction was perceived). Despite the fact that the majority stated that they perceived a distinction between health education and health promotion, many ward sisters expressed difficulty in defining a distinction and this was reflected in hesitant responses which often lacked clarity. In many cases it was not possible to

determine on what basis a distinction was being made. This lack of clarity or forethought is further underlined by the fact that responses to the initial part of the question asking respondents for their interpretation of the concepts were rarely characterized by a distinction between the two. Rather, as indicated above, ideas that emerged from both individual respondents and from the sample as a whole did not relate specifically or consistently to either health education or health promotion. That is, the majority of ward sisters appeared to use the terms interchangeably prior to being specifically asked about any perceived distinction between them.

Responses concerning the way in which distinctions were made between health education and health promotion were analyzed using content analysis and revealed that a number of common themes could be identified. It appeared that ward sisters distinguished between health education and health promotion in one of two ways. Whilst these are linked rather than mutually exclusive, for the sake of clarity they are presented separately below.

#### a) Teaching versus selling health

Some ward sisters (17% n=23) described the difference between 'health education' and 'health promotion' by focusing on the semantic meaning of the words 'education' and 'promotion'. Thus, health education was frequently referred to as a method of teaching or educating about health or illness, whilst health promotion involved the promotional tactics of selling, pushing or advertising the health message. The following responses are typical of this theme:

*"Education . . . . . I think you're actually talking to the person, giving them advice and giving pros and cons of certain things . . . . . the promotion side, well, when a patient actually walks in the ward we've got posters, booklets everywhere and that way you promote it, like advertising, really."*

*"Health promotion sounds a bit more forceful (than health education) doesn't it? It sounds pushier – it's the strong sell."*

*"Health education is actually informing people, teaching if you like. Promotion is probably advertising more about what you're doing, would be my interpretation of it; you have a week of some sort of campaign, if you like, really pushing something."*

*“Health education is offering the knowledge to staff and patients, giving them the information. Health promotion is similar, but you may have to use more explanation and encouragement.”*

Together with the hesitancy and lack of clarity which characterized many responses, it is possible that interpreting the distinction between health education and health promotion in this way reflected a lack of previous consideration of this issue. That is, in focusing on the semantics of the words, these ward sisters were able to offer an immediate or “off the cuff” response based on their knowledge of the meaning of “education “ and “promotion” in other contexts, without any previous consideration of the distinction between these terms.

Linked to the teaching versus selling distinction was the idea expressed by some (13% n=17) that whilst health education was perceived to be carried out with individuals at a one-to-one level, health promotion was seen as being aimed at the public at large, with a less specific focus. This view was expressed by the following ward sisters:

*“Health promotion is . . . . I would think, having displays and leaflets available, whereas health education is more specific and honed in on a patient.”*

*“Health promotion conjures up the idea of displays – it’s like a massive, mass appeal to the public, whereas health education is much more earthy and tends to get to the individual.”*

*“We had a health promotion study day, so it was making people aware, you know, you could visit this study day and there were stands and different things, and it was making people aware. Whereas when you’re educating somebody it tends to be something more specific, rather than something more general.”*

In one sense, such comments appear to indicate a recognition of the wider level at which health promotion is believed to operate. However, analysis revealed a lack of reference to the wider social, political and structural determinants of health and/or policies designed to influence these. Rather, the focus of health promotion was perceived to be broader in the sense that it addresses a wider audience simultaneously through a range of methods. This is also exemplified by the following quote:

*“Promotion . . . . I see it as people actually going out into other areas, looking at people. For example, like the cervical smears or the breast screening, you see people in these big vans in town checking smoking, things like that, or people actually coming out to you and talking to you as a body of people, offering you a service.”*

Thus individuals and their health behaviour are still perceived to be the target of this apparently broader approach. The above quote also exemplifies an interpretation of the concepts as involving a prescriptive as opposed to a collaborative approach, through the respondent's use of the words “*looking at people*” and “*checking smoking*”.

Thus, many ward sisters distinguished between the concepts on the basis of health education involving teaching individuals and health promotion requiring publicity or marketing of health messages to the public at large. The latter interpretation of health promotion has been criticized for a number of reasons (see Chapter One).

Only one ward sister appeared cognisant of the structural influences on health that health promotion also addresses. In defining the distinction between health education and health promotion, she expressed the view that:

*“Health promotion is encouraging and making it easier for them (people) to engage in healthier lifestyles. It's about us manipulating the environment, about me as a professional saying it's not all up to individuals – governments have a part to play too. It's more sociological.”*

This illustrates that not only was this ward sister unique in her awareness of the structural or environmental influences on health, she also appeared to be unique in identifying a political or lobbying aspect to her role as a nurse in health promotion. None of the other 131 respondents made reference to this aspect of the nurse's role. Interestingly, data analysis also revealed that this respondent was amongst the most highly qualified academically in the ward sister sample, having obtained a Master's degree in Nursing as well as a Diploma in Nursing and a Certificate of Education, which suggests that further or higher education may be related to the comprehensiveness and complexity of respondents' perceptions, a point returned to in Chapter Six.

**b) Ill people versus healthy people**

A second group of ward sisters (19% n=25) distinguished between health education and health promotion on the following basis: health education was perceived to involve illness-related education with individuals who had pre-existing illness, whilst health promotion involved education or advice to healthy people about the promotion of good health generally. This theme is reflected in the following comments:

*“Health education suggests to me someone who is in need of being taught specific things. Health promotion – is – um – to me, it means people who have not necessarily got a problem, more preventative.”*

*“Health promotion is the preventative stage before people become patients. Health education to me tends to be more hospital-based, where you’ve brought someone in and they have diabetes or have had a heart attack or whatever, and so you’re educating them about something they already have, as opposed to educating them before they presented with it.”*

*“I see health promotion as being more of a preventative, educational – um – role, I suppose. Probably more from the point of people that are well rather than people that are ill.”*

This idea is related to an interpretation of health promotion as having a more positive health focus. As outlined in Chapter One, it has been suggested that this is an inadequate account of the meaning of health promotion. This idea is also linked to the well known concepts of primary, secondary and tertiary levels of prevention: it could be said that ward sisters perceived health promotion to have primary prevention as its focus, whereas health education involves tertiary prevention, to limit the effects of already established illness. Interestingly, despite the emergence here of primary prevention as a feature of some nurses’ understandings of the concepts, health promotion remains connected to prevention as opposed to the promotion of positive health. As suggested in Chapter One, whilst these two concepts are not entirely separable, this is again indicative of an illness-orientation to understanding of these concepts and reinforces findings presented earlier in this Chapter.

To summarize, data analysis revealed that ward sisters’ responses frequently lacked clarity or forethought when asked to define how they distinguished between health education and health promotion. Distinctions articulated could be classified in one of two ways. In conjunction with data analysis of meanings ascribed to these concepts



(part (i) of the question), the findings indicate that certain orientations to health education and health promotion were held by the ward sisters. Underlying all of the categories identified from the data is a physical illness and problem-orientated, preventative focus on individuals and their lifestyles. Although there was a recognition by some that promotion of good health was an important goal, an illness-orientation pervaded the majority of responses. Many of the concepts inherent in the more recent paradigms of health education and health promotion as outlined in Chapter One were lacking in the ward sisters' interpretations. Whilst a minority of the sample mentioned self-responsibility and informed choice as important elements of health education and health promotion, the concept of empowerment was not directly identified as a constituent of health education or health promotion by any of the 132 respondents. Other key principles such as participation, equity, collaboration and healthy public policy were all absent from ward sisters' responses and thus presumably their understandings. In addition, only two appeared to understand the wider structural influences on health or the policy level at which most commentators suggest health promotion operates. The implications of these perceptions are discussed in Chapter Six.

### **Ward Sisters' Perceptions of Nurses' Health Education and Health Promotion Practice**

An open-ended item included in the schedule required the ward sisters to describe the health education and health promotion activities that nurses were currently engaged in on their respective wards. In addition to providing an important overview of perceived practice, these data also illuminate ward sisters' interpretation of the concepts and of nurses' role in enacting these in acute ward settings. Whilst responses were limited to some extent by what was felt to be actually currently occurring on the wards, statements about nurses' potential role could also have been elicited in the context of this question. That is, the researcher stressed that she was interested in an honest description of practice in conjunction with current constraints in operation. Data on potential aspects of the nurse's role in health education and health promotion currently not being fulfilled due to any constraints could therefore also have been expected to emerge, either in response to this item or a subsequent one asking respondents specifically about inhibitory factors in operation (see below).

Where applicable the results of data analysis on responses to subsequent, more focused items in the interview schedule are also included. These involved questions about a number of health education and health promotion activities pre-determined for inclusion

by the researcher (see Appendix 2). Thus, although responses to these latter items do not specifically represent the ward sisters' own interpretations, they nevertheless proved a useful adjunct to the inductively derived categories emanating from the open-ended item described above. These findings are presented below.

Content analysis of the data revealed the emergence of a number of categories in relation to ward sisters' interpretation of nurses' health education and health promotion role on their respective wards. Table 5 illustrates these, together with numbers of respondents who identified each activity.

**Table 5: Types of health education and health promotion activities identified by ward sisters**

| Type of health education/promotion activity identified by ward sisters | Number of ward sisters citing practice of the activity |
|--|--|
|  |  |
| Patient education  | 79% (n=104)  |
| Healthy lifestyle advice   | 67% (n=88)   |
| Information giving   | 45% (n=60)   |
| Encouraging relative participation                                     | 20% (n=27)   |
| Encouraging patient participation                                      | 10% (n=13)   |

NB More than one response was possible.

#### Patient Education

During the process of content analysis of responses related to this item, an identifiable theme emerged which was consistent with characteristics of traditional types of patient education as outlined in Chapter One. Table 5 shows that the category of "patient education" was identified as an element of the nurse's health education and health promotion role by over three quarters of respondents. Of those interviewed, 79% (n=104) expressed the view that nurses were currently engaged in this type of activity on their respective wards. Examples of patient education were the most frequently cited category of response and this finding is obviously related to respondents' understandings of the concepts of health education and health promotion presented above. That is, the prevalence with which patient education was cited is likely to be a reflection of the finding described above that educating, informing and advising

individuals were seen as important components of the concepts of health education and health promotion by ward sisters.

Ward sisters mentioned a wide range of topics about which nurses were educating patients, as the statements below exemplify:

*“We (also) have very practical things to do with patients, for example, teach them how to flush their Hickman lines, and dressings.”*

*“A small percentage of our patients we really have to consciously educate – about leg ulcers, the importance of limb movements and post-operative complications as a whole.”*

*“We will explain what diabetes is, depending on what level they can accept, and we go through injections and the different techniques, depending on what they’re using.”*

As the above quotes illustrate, examples of patient education cited generally revolved around the illness that the patient was experiencing and the implicit aim of the education was to help the patient manage the illness as part of the rehabilitation process.

Further information about what the ward sisters meant by patient education emerged when they were specifically asked by the researcher in a subsequent item included in the schedule to elaborate on examples of this activity occurring on the ward. The types of patient education that emerged, together with the numbers of respondents citing each of them are presented below:

|                           |            |
|---------------------------|------------|
| Management of the illness | 45% (n=59) |
| Diagnosis                 | 27% (n=35) |
| Lifestyle adjustments     | 23% (n=31) |

NB More than one response was possible.

Three major categories could be identified from these responses, the most frequently cited being education about management of the patient’s illness (45%, n=59). That is, these ward sisters perceived that nurses were educating patients about the practical management or skills involved in dealing with an illness, usually a chronic illness. The following examples provide clarification of this category:

*“ . . . teaching patients to look after their own stoma, or teaching them to give enemas themselves, or how to empty urinary catheters . . . ”*

*“(We teach patients) how to use their walking aids . . . how to do their pin-site dressings if they need to do them at home.”*

*“We do teach patients how to self-catheterize . . . . there are set printed booklets about this. We give them the booklet and then go back later once they’ve read it and understood it, and go through the actual procedure with them. If they feel happy with it, we just go in and supervise next time.”*

In response to this question about patient education, a smaller proportion (27%, n=35) gave examples of nurses educating patients about their diagnosis. This included education about the aetiology of the condition and/or some of the anatomical or physiological principles involved in the illness or diagnosis as well as explanations about patients’ symptoms.

The third category identified in relation to types of patient education was ‘lifestyle adjustments’. These ward sisters (23%, n=31) felt that nurses were educating patients during their stay about how to live with the illness and adjust their lifestyle – either permanently or temporarily – to accommodate their illness and/or prevent complications occurring in the future. This idea is reflected in such comments as:

*“With amputees, they have a lot of needs with regards adjustment and need advice on transferring and learning to walk again. The physio does much of this, but we carry it on.”*

*“We teach people to adjust to a new way of life, for example, stoma patients, amputees and mastectomies . . . . we give discharge advice, what they should and shouldn’t do.”*

All of the sub-categories identified from analysis of responses to this question on examples of patient education reveal a pre-occupation with physical disease and its management. Whilst it is recognized that to some extent they are inseparable, the ward sisters did not specifically link patient education to aspects of the patient’s psychological or social well-being. Possible examples would include education about psychological adjustment to altered body image following amputation or mastectomy and / or exploring the social implications of living with a chronic illness. The

relationship between patient education and its ability to increase feelings of control could also have been commented on. A recognition that patient education needs to be individualized, as opposed to standardized, (as outlined in Chapter One) was also lacking. Related to this, the examples of patient education that nurses were believed to be involved in as part of their health education and health promotion role contained a lack of reference to the two-way or collaborative nature of this activity. If educating patients is a potential vehicle for patient control and thus empowerment (as suggested for example by Wilson Barnett and Osborne (1983) and Tones (1993) as opposed to a prescriptive, didactic method of imparting advice or information then it is essential that its collaborative nature is recognized. However, the data gave no indication that the ward sisters had internalized this idea, which therefore has implications for the extent to which they recognized the empowerment role of the nurse in relation to health education and health promotion, a point returned to below. Taken together, it seemed that these ward sisters were operating with traditional ideas about patient education, rather than more enlightened ones.

### Healthy Lifestyle Advice

Table 5 shows that a second category emerging from the data in response to the item asking for a description of nurses' current practice on the ward, was that of "healthy lifestyle advice". This refers to examples given spontaneously by the ward sisters of nurses' involvement in offering advice or information to patients about various aspects of their lifestyles or habits which may influence their health status. This theme was identified in 67% (n=88) of the responses - that is, healthy lifestyle advice was the second most frequently identified aspect of nurses' health education and health promotion role after patient education. The following quotes are typical of these ward sisters' perceptions:

*"If someone is having problems with constipation, we don't need to refer them to a dietician for a high-fibre diet. We can do these little things by sitting down with the menu and asking the patient about the choices made."*

*"It's things like the smoking – the diet – they're the aspects we like to try and concentrate on."*

*"Because some of our patients do have problems with constipation, we discuss their dietary intake of fibre."*

Respondents believed that the areas of patients' lifestyles that nurses were particularly likely to address revolved around their dietary and smoking habits. Comments frequently referred to these aspects as opposed to other healthy lifestyle issues such as management of stress, as the above excerpts illustrate. Once again, this may be interpreted as a reflection of the ward sisters' understanding of the concepts themselves (see above) which showed a strong emphasis on lifestyle related issues, particularly individuals' smoking and dietary habits. This is indicative of a close relationship between these nurses' interpretation of the meaning of health education and health promotion on the one hand, and perceptions about nurses' role in them on the other (see Chapter Six for further discussion of the relationship between nurses' perceptions and practice).

Further information about the particular types of healthy lifestyle advice that nurses were perceived to be involved in giving derives from an item included in a subsequent section of the interview schedule. Ward sisters were specifically asked by the researcher to elaborate on nurses' involvement in giving advice to patients regarding aspects of their lifestyle on their respective wards. Data analysis revealed that respondents identified a number of subjects about which nurses were believed to be offering advice in relation to a healthy lifestyle. The main subjects identified together with the number of ward sisters who cited each subject were as follows:

|          |            |
|----------|------------|
| Smoking  | 52% (n=68) |
| Diet     | 39% (n=52) |
| Alcohol  | 11% (n=15) |
| Exercise | 9% (n=12)  |
| Stress   | 7% (n=9)   |

NB More than one response was possible.

Five main categories of healthy lifestyle advice emerged from ward sisters' responses: nurses were considered to be giving advice on smoking, diet, alcohol, exercise and stress by varying proportions of the sample. The most common areas of patients' lifestyles that were believed to be being addressed by nurses were smoking (52%, n=68) and diet (39%, n=52). This further substantiates the ward sisters' emphasis on nurses' involvement in lifestyle advice about patients' smoking and dietary habits presented above. Whilst over half of the sample mentioned involvement in smoking advice, only 11% (n=15) gave examples of nurses advising patients about alcohol intake and smaller proportions cited advice about exercise (9%, n=12) or stress

management (7%, n=9) being given by nurses. In addition, only 3% (n=4) gave examples of nurses' involvement in safe sex advice and similarly only 5% (n=6) mentioned advice on contraception. Further, only one charge nurse on an orthopaedic trauma ward said that nurses gave advice to patients on road safety, and only a single ward sister felt that patients were given advice on the dangers of the sun and sun-bathing.

Analysis of the ward sisters' comments about nurses' involvement in healthy lifestyle advice also revealed that, once again, these lacked evidence of a recognition of the essential two-way or collaborative nature of the advice-giving process. This finding is commented on elsewhere in this Chapter and substantiates the finding that this idea was also absent from the ward sisters' understanding of the concepts of health education and health promotion themselves. Also absent from the responses about healthy lifestyle advice was any comment about the broader, structural influences on individuals' lifestyle decisions in relation to their health. No mention was made of nurses' recognition of this in the advice-giving process. Whilst this item did not specifically address this issue, some statements about the structural influences on individuals' lifestyles may have been expected in the light of their importance in potentially determining both the type of advice and the way in which it is given to patients (see Chapter One). The absence of such comments is further evidence of the simplistic, reductionist ideologies with which these nurses appeared to be operating and, once again, is closely linked to their interpretation of the concepts themselves.

### Information-Giving

In addition to patient education and healthy lifestyle advice, many ward sisters described nurses' involvement in information-giving with patients on their wards as a part of their role in health education and health promotion, as the following comments indicate:

*"Patients do get a lot of opportunity to ask questions, and are given information about their pre-op management and their aftercare."*

*"We certainly feel that a patient has every right to information."*

*"We're very keen that patients know exactly what is happening to them, and so we give information about their disease, their treatment."*

*“We rely a lot on written information to inform the patient.”*

Table 5 shows that the information-giving aspect of the nurse’s role was cited by almost half of the sample (45% n=60). The comparatively large proportion of the sample citing this activity may be a reflection of the way in which these nurses interpreted the meaning of the concepts themselves, as mentioned above. That is, health education and health promotion were largely perceived as consisting of a process of information, education and advice giving to individuals. Alternatively, or in addition, this finding may represent a recognition of the now substantial body of research-based knowledge on the beneficial effects of information-giving to patients. That is, they were familiar with this rather more traditional aspect of the nurse’s role in health education and promotion.

Analysis of responses to a subsequent item introduced by the researcher and which specifically requested examples of information-giving occurring on the ward allows further light to be shed on this. Analysis revealed that a number of different types of information-giving were perceived by the ward sisters to be occurring on their wards. The categories or types that emerged and the frequency with which they were cited were:

|                                     |             |
|-------------------------------------|-------------|
| Pre-procedural advice               | 58% (n=77)  |
| Pre-operative advice                | 47% (n=62)* |
| Advice about treatment/plan of care | 27% (n=36)  |
| Orientation information             | 14% (n=18)  |

NB More than one response was possible

\* This response was only applicable for ward sisters on surgical wards

As the above shows, when specifically asked for examples of the types of information that nurses were involved in giving to patients, ward sisters were most likely to give examples representing ‘pre-procedural advice’ (58%, n=77). That is, advice or information given to patients in anticipation of an impending procedure or investigation in order to promote coping and/or recovery. Examples of actual procedures cited by the ward sisters were obviously dependent on the ward speciality, but commonly mentioned were information-giving prior to scans, X-rays and various radio-opaque investigations, as well as more ward-specific procedures such as cardiac catheterizations. These examples referred to information given prior to a procedure not requiring an anaesthetic – 47% (n=62) of the ward sisters also cited examples of nurses



giving advice pre-operatively to patients. That is, information about events leading up to surgery as well as details about what to expect in the immediate post-operative period. Obviously, examples of this nature were only applicable to ward sisters on surgical wards; analysis of responses from those on surgical wards revealed that 82% (n=62) cited that nurses were involved in giving pre-operative advice of this type.

A smaller proportion (27%, n=36) felt that nurses were engaged in giving patients information about their treatment or plan of care during their in-patient stay. These ward sisters referred to examples of nurses outlining what was expected to be in store for the patient, and the following comment illustrates this:

*“On admission, patients are told what to expect and are told the source of possible problems and how nurses are going to go about preventing these problems.”*

It is interesting to note the ward sisters' choice of adjectives in the above response. That is, that patients are “*told*” both what to expect and “*told*” about possible sources of problems and it is the nurses, as opposed to the patient himself / herself, who will go about preventing these, indicating a lack of recognition of the latter's expertise and responsibility and a one-way approach to the process of giving information.

A final sub-category to emerge in relation to the types of information-giving that nurses were perceived to be involved in was ‘orientation’ information. Fourteen per cent (n=18) of ward sisters stated that on their wards, information was given to patients about such things as the layout of the ward, meal-times and visiting times, and the meaning of the different types of uniform worn by nurses. The quotes below are typical of this category of response:

*“On admission we give patients a detailed tour of the ward and tell them how to get hold of us if they need to.”*

*“On admission patients are welcomed and given some information at that stage. They are shown to their beds and shortly after that a qualified nurse . . . . will go through . . . . visiting times and everything to do with the hospital.”*

*“Patients are given an admission sheet, which gives them the name of their nurse and doctor, visiting times and facilities, and explaining that we will be involving them in their care and to tell us how they feel about things.”*

It is interesting to note that this response category is characterized by an assumption that such aspects as visiting times are acceptable to the patient.

The above findings illustrate that information-giving about a number of different issues was perceived by a large proportion of the sample to constitute part of nurses' health education and health promotion work in acute ward settings. Whilst none of the sample mentioned the concept of empowerment directly in relation to hospital nurses' roles and responsibilities, it might be argued that, together with these nurses' emphasis on patient education, that they were in fact cognisant of the need for the patient to take control or feel empowered and education and information-giving were seen as legitimate ways of achieving this. As outlined in Chapter One, these activities are considered by Wilson Barnett and Osborne (1983) and Tones (1993) as mechanisms by which patient control and thus empowerment may be fostered. However, it is unclear from the data presented above whether the ward sisters had actually internalized the concept of empowerment as an important constituent of information-giving and health education and health promotion. If they had, it is surprising that none of them specifically mentioned the term "empowerment". In addition, the responses (as exemplified above) lacked evidence of a recognition of the importance of the two-way nature of the information-giving process if it is to offer empowerment to the patient. Neither did responses contain reference to the idea of information-giving to the patient about ways in which he/she may register his / her opinions or feelings or other strategies for patient empowerment at the ward or hospital level. The latter response (above) is exceptional to this trend in that, by stating that the patient is required "*to tell us how they feel about things*" the ward sister appears to recognize the patient's contribution to the information-giving process.

In the context of the findings presented elsewhere in this Chapter, it seems more likely that in general, information-giving and education were perceived as a process of furnishing individual patients with knowledge from a nurse for largely pragmatic purposes or in order that the patient is able to comply with the system. This latter feature of patient education has been contrasted to self care by Levin (1978) and it was suggested in Chapter Two that it also contradicts the principles believed to characterize health promotion.

#### Relative Participation in Care

Table 5 indicates that, when asked to describe the types of health education and health promotion activities that nurses were engaged in on their respective wards, 20% (n=27)

of respondents spontaneously cited examples of nurses encouraging relatives to participate in the patient's care. The following are examples of responses identified in this category:

*"We (also) explain what diabetes is . . . . . we go through the injections and the different techniques . . . . . and try and encourage the relatives and close friends to become involved so it's not just the patient we're teaching."*

*"If a visitor wants to come in and bath someone, that's fine. One gentleman at present whose wife's had a sub-arachnoid haemorrhage comes every mealtime and feeds her."*

The first comment illustrates that examples of relative participation were often associated with education of the patient or relative. This may help explain the prevalence with which it was cited as an example of nurses' involvement in health education and health promotion. That is, many respondents were able to give examples of patient education occurring on their wards, and this may have prompted the ward sisters to consider relative participation in care as an element of this. This would certainly help to explain the discrepancy between participation being identified by only a small number of respondents in relation to meaning attributed to the concepts, and yet 20% (n=26) of the sample were able to cite it as an example of nurses' health education and health promotion role on their wards.

Further information about nurses' involvement in encouraging relatives to participate in care derives from a subsequent question on this activity selected for inclusion by the researcher. Examples of relative participation were requested from each respondent, drawing on their knowledge of nurses' current practice on their ward. Data analysis revealed the emergence of a number of sub-categories of relative participation cited by varying proportions of the sample, as presented below:

|  |            |
|--|------------|
| Patients' activities of daily living       | 37% (n=49) |
| Management of patients' illness activities | 33% (n=43) |
| Recipients of information                  | 25% (n=33) |
| Encouraged to stay                         | 8% (n=11)  |
| "Nursing" activities                       | 4% (n=5)   |
| Decision-making                            | 4% (n=5)   |

NB More than one response was possible.

Just over a third of ward sisters (37% n=49) felt that relatives were being encouraged to participate in care through involvement in the patients' activities of daily living.

Examples involving bathing and feeding were particularly common:

*"With very poorly patients, we encourage relatives to come in and help feed them or help to bath them."*

*"Patients who are terminally ill, we encourage relatives to come in to help wash the patients and give bedbaths in the morning with the nurse."*

*"We have them come in and feed them at mealtimes if the patient can't do it themselves, and they want to come and do it."*

A similar number (33%, n=43) felt that relatives were being encouraged by nurses to become involved in activities aimed at managing the patient's illness. Examples ranged from positioning of limbs of stroke patients to care of patients' stomas and Hickman lines. Frequently, these responses were associated with a recognition that relative participation was essential (i) if the patient was unable to perform such activities himself and/or (ii) in preparation for the relative's role as carer after discharge. Analysis revealed that 23% (n=30) of ward sisters gave the latter as a major motivation for encouraging relatives to participate in the patient's care whilst in hospital. One ward sister's response was typical of this idea:

*"Patients' relatives are often quite shocked if they are asked to participate – but the next day the patient is going home, so they are going to have to help themselves."*

This suggests that reasons of expediency may underlie any encouragement given by nurses to relatives to participate in the patient's care.

One quarter of the ward sisters (25%, n=33) felt that relatives were participating in care on their wards by virtue of the fact that they were the recipients of information given to them by nurses. This information usually related to details of the patients' condition or expected care whilst in hospital, as the following comments indicate:

*"With the cardiac patients, we give relatives the leaflets as well, and tell them to go home and read them."*

*“Chemotherapy patients’ families are involved a lot – we like to talk to them about what is happening.”*

*“We do explain to relatives what is being done.”*

*“Apart from giving the relatives information about the patients’ care, there’s not really much involvement.”*

Whilst the giving of information to relatives could be seen as a form of empowerment, this was not specifically mentioned by any of the respondents in relation to this activity. As previously discussed, whether information-giving is empowering or not may depend on the way in which it is communicated and the underlying reason for giving it. Alternatively, the receipt of information as a form of participation may be indicative of a passive rather than an active role in participation for the relative. The idea of “passive” participation is also reflected in the 8% (n=11) of ward sisters who identified relatives being encouraged to stay with the patient on the ward as an example of relative participation in care. One ward sister said:

*“Relatives are allowed to stay if they particularly want to – we put a bed into the room, or we use a spare one.”*

However, encouragement to stay on the ward and remain with the patient does not necessarily imply that the relative is actually being encouraged to participate in the care of the patient - it is equally possible that the relative remains present, but in a passive observer role. It is also interesting to note the ward sister’s use of the term “*allowed to stay*” in the above quote. This is indicative of a perceived power imbalance between nurse and relative roles and is therefore contradictory to the idea of participation in care as an element of health education and health promotion.

Finally, small numbers of respondents stated that nurses were involved in encouraging relatives to become involved in activities traditionally carried out by nurses (4%, n=5) and to share in decisions related to the patient’s care (4%, n=5). Examples of the former included relatives stripping and making beds as well as recording vital signs.

#### Patient Participation in Care

Data analysis also revealed that some ward sisters considered encouraging patient participation in care to constitute a part of nurses’ practice of health education and health

promotion. This category was identified from examples given by 10% (n=13) of the sample, as shown in Table 5. The following quote from a ward sister describes the nurse's role in encouraging patient participation on her ward:

*"We involve all patients in planning their own care. They have a welcome letter on arrival, which makes it explicit to patients that we would like to work in partnership with them."*

It is perhaps significant that this aspect of nurses' health education and health promotion role was identified by only a small number of respondents in comparison with those who mentioned patient education and information-giving. It is likely that this finding is closely linked to the ward sisters' interpretations of the concepts of health education and health promotion (see above). These were characterized by a lack of reference to collaboration and participation except in relation to the idea of self-responsibility for one's own care. Nevertheless, it is interesting that a small number of respondents did perceive encouraging participation as a part of nurses' role on their wards and the above comment is suggestive of a recognition of the partnership or collaborative nature of health education and health promotion.

Additional interesting data on the encouragement given to patients to participate in their care emerged in relation to a subsequent question which specifically addressed this activity. The researcher was concerned to explore this aspect of health education and health promotion in a hospital setting and therefore each ward sister was asked to describe any examples of this activity currently occurring on their respective wards. Thus, even those respondents who had not previously mentioned patient participation as a part of health education and health promotion and the nurse's role in this were asked to describe examples of this practice. Interestingly, the number of respondents who were able to give examples (see below) far outweighed the number (10% n=13) who spontaneously mentioned patient participation without prompting by the researcher. This suggests that the limited types of health education and health promotion activities spontaneously described by the ward sisters may be constrained by their own understanding of the concepts rather than by nurses' actual practice on their wards. (The relationship between nurses' perceptions and practice of health education and promotion is discussed further in Chapter Six).

Analysis of responses to this item revealed that a number of distinct sub-categories of patient participation could be identified. These are presented below, together with the number of ward sisters who cited them:

|                                  |            |
|----------------------------------|------------|
| Management of illness activities | 45% (n=60) |
| “Nursing” activities             | 37% (n=49) |
| Decision-making                  | 30% (n=39) |
| Activities of daily living       | 28% (n=37) |

NB More than one response was possible

Ward sisters described four main categories of patient participation, which were similar to those identified for relatives' participation in care. The most commonly cited examples involved encouraging patients to participate in the management of their illness. That is, 45% (n=60) of ward sisters felt that nurses were encouraging participation in activities such as administration of insulin injections and self-diagnostic procedures such as peak flows and urine testing. These examples were usually associated with managing chronic, as opposed to acute, illnesses such as diabetes or chronic obstructive airways disease. Presumably, some or all of these patients would have been involved in managing these aspects of their illness prior to admission to hospital and if so these examples represent a continuation of previous participation in illness management, rather than a new opportunity to participate. A second category, mentioned by over a third (37%, n=49) of ward sisters was that of encouraging participation in what could be regarded as activities traditionally carried out by nurses. Examples given included patient involvement in documenting fluid balance and observations of vital signs, giving own suppositories and shaving prior to surgery where appropriate. Such comments are suggestive of an erosion of the traditional roles of nurse and patient and the inherent unequal distribution of power in favour of the former. This is also indicated by a third category to emerge from ward sisters' responses about participation in care: 30% (n=39) stated that nurses were encouraging patients to be involved in making decisions about their care and treatment whilst in hospital. This is evident in the following responses:

*“We think that patients have a right to have a say in what is going to happen to them.”*

*“There's a lot of changes in the current way of thinking . . . . if they don't want a certain type of procedure why then force the issue? We leave it to their choice, as long as we've educated them . . . . and then it's up to them.”*

*“If a patient doesn't want his breakfast at 8 am, we leave him sleeping, he doesn't have to have it. We try to have that attitude.”*

Quite often, joint care planning was stated to be an activity that facilitated joint decision-making. As one ward sister commented:

*“With their care plans, we try and discuss things with them . . . . for example, one patient was recently involved in deciding his own insulin doses. It went up and down each day, and continuous ambulatory peritoneal dialysis patients will decide whether they need an extra strong or a weak bag.”*

These examples of patients being encouraged to be involved in what were once traditionally considered nursing activities and in decisions about care whilst in hospital suggest that empowering patients to take control is a feature of nurses' health education and health promotion practice on these wards. Although the term “empowerment” was not directly mentioned by the ward sisters, these examples would appear to indicate that that was in fact what was going on. This point is returned to in the light of the findings from observation of nurses' practice on a number of case study wards presented in Chapter Five.

Finally, and perhaps less radically, 28% (n=37) of respondents cited that nurses on their wards were involved in encouraging patients to participate in activities of daily living such as dressing, mobilising and feeding. The comments below exemplify this theme:

*“We encourage them to mobilise quickly post-op and encourage them to do as much as possible for themselves and (we) give them good reasons why.”*

*“With stroke patients, it's (participation in ) general hygiene and general care. It's really about encouraging self care for when the patient goes back into the community.”*

*“You wouldn't see anyone washing the face of a patient if they can do it themselves.”*

*“The policy is for nurses to encourage them to take their own fluids - we don't have to go to them every half hour and offer them a drink.”*

These comments indicate that this type of patient participation is related more to a rehabilitation strategy as opposed to a desire to maximise patient control, responsibility and power per se. It is possible that purely practical reasons also account for the



prevalence of examples of participation in management of illness activities – i.e. nurses are considering rehabilitation and coping rather than deprofessionalization and democratization.

### The Focus on Health Education with Individual Patients

Data were also analyzed both qualitatively and quantitatively to reveal the different ways in which nurses were believed to be implementing the activities described by the ward sisters. A diverse spectrum of mediums for carrying out health education and health promotion were cited: examples ranged from written materials such as a ward information book or health related magazine articles to photographs, posters, telephone line advice lines and drop-ins and support groups for patients. Many innovative ideas appeared to have been developed on the wards; for example, two ward sisters mentioned the use of relaxation tapes for patients whilst three identified the development of pre-admission clinics as potential vehicles for health education and health promotion. The most commonly cited (27%, n=36) methods for implementing health education and health promotion were via leaflets and booklets on such topics as sources of dietary fibre and prevention of coronary heart disease. Smaller numbers mentioned posters (7%, n=9), support groups for patients attached to the ward (7%, n=9) and health education notice boards (6%, n=8). Whilst such diversity and innovation is encouraging, these data also reveal that most activity is at the one:one, nurse:patient level - or the level at which most commentators suggest health education operates. However, none of the ward sisters mentioned the education of key policy makers as forming a part of nurses' role - an activity which is also considered an essential component of health education, as previously outlined in Chapter One.

With the exception of one respondent, there was a lack of reference to nurses' involvement in activity at a health promotion, or broader policy level either at ward, organizational or broader community-wide level. This substantiates findings presented elsewhere in this Chapter. The above ward sister reported that she was engaged in collaborative work with other professionals and hospital staff in order to influence hospital health promoting policy. She was part of a multi-disciplinary working group, including a Health Promotion Officer attached to the hospital and the catering manager, which had been looking at the menu choices available to staff and patients in the hospital. The ward sister reported that a number of potentially health promoting changes had been made as a result of this group. This was also the only example of nurse involvement in multi-sectoral or inter-disciplinary activity related to health promotion cited during the course of data collection. Reference to this important

principle of health promotion was absent from the remainder of the 131 responses. Data analysis also revealed that this respondent was the only ward sister currently undertaking further education specifically related to health education in that she was studying for a Health Education Certificate on a day release course at a local college. This point is returned to in the discussion of results in Chapter Six.

Again, the above findings are closely linked to the ward sisters' understanding of the concepts of health education and health promotion themselves and may be a reflection of this. Alternatively, this finding may be explained by a real lack of engagement by nurses in policy level activities or multi-disciplinary ways of working. This point is also returned to in the light of the findings from the case study wards in Chapter Six.

To summarize, ward sisters were asked to describe the types of health education and health promotion activities nurses were currently engaged in on their respective wards. This question elicited important data about the way in which the concepts are interpreted and nurses' role in this in acute ward settings. A number of different activities were spontaneously described by the ward sisters, and several subsequent items included by the researcher allowed further exploration of these activities. Educating patients, advising them about healthy lifestyles and imparting information to them were the most frequently cited activities. Smaller numbers of respondents identified encouraging relative and patient participation in care as forming a part of nurses' health education and health promotion role on their wards. Data analysis revealed that the activities identified as a legitimate part of nurses' health education and health promotion work were inextricably linked to the way in which the concepts themselves were interpreted. Thus, the findings presented substantiate those described earlier. They indicate that the ward sisters' perceptions about the nurse's role in health education and health promotion are limited in complexity and comprehensiveness.

### **Factors Influencing Nurses' Health Education and Health Promotion Practice Identified by Ward Sisters.**

Two open-ended items included in the schedule required respondents to identify factors that, in their opinion: (i) inhibited nurses' ability to put health education and health promotion into practice and (ii) currently facilitated, or would potentially facilitate, this aspect of nurses' practice. Content analysis revealed a range of different factors that were cited by the ward sisters. The frequency with which each factor was quoted in the sample as a whole was then calculated to give an indication of its prevalence and representativeness. The results are shown in Tables 6 and 7.

### Inhibiting Factors

Table 6 shows the factors given by the ward sisters which were believed to currently inhibit the practice of health education and health promotion by nurses at ward level.

**Table 6: Factors inhibiting health education and health promotion practice cited by ward sisters.**

| <b>Inhibiting factor identified by ward sisters</b> | <b>Number of ward sisters</b> |
|---|-------------------------------|
|   |                               |
| Lack of time  | 107 (81%)                     |
| Lack of patient receptivity                         | 88 (67%)                      |
| Lack of knowledge/skill                             | 70 (53%)                      |
| Nurses' characteristics                             | 54 (41%)                      |
| Patients' length of stay                            | 46 (35%)                      |
| Inadequate staffing                                 | 44 (33%)                      |
| Prioritizing care                                   | 40 (30%)                      |
| Medical staff                                       | 28 (21%)                      |
| Workload  | 26 (20%)                      |
| Interference with patients' freedom of choice       | 22 (17%)                      |
| Social and economic constraints                     | 11 (8%)                       |

It is not the researcher's intention to explore each of these variables in any great depth in relation to the way in which they were perceived to inhibit practice. Rather, the findings are used selectively for the way in which they illuminate the central thrust of this study - that is, nurses' interpretation of the meaning of health education and health promotion and their role in this. The relevant factors are discussed in turn below.

#### Lack of time

Many ward sisters considered that there was insufficient time available to nurses on their wards to enable them to put health education and health promotion into practice. Lack of time was the most frequently quoted inhibitor of practice and was cited by 107 (81%) of the sample. The following comments by ward sisters are typical:

*"The more you raise people's awareness of what should be done, the more you stress them, because they just don't physically have the time to do it."*

*"Time is a problem, you can't sit down and have a chat about education, you can do it when you're giving a bedbath but you also need to put half an hour aside and not be disturbed and that's impossible"*

A number of other factors cited by the ward sisters as inhibitory influences are closely linked to lack of availability of time to implement health education and health promotion. These include the patient's length of stay on the ward which was felt to be influential by 46 respondents (35%). It was suggested by these ward sisters that patients were now on the ward for a much shorter period than in the past and that this had implications for the amount of health education and health promotion nurses were able to undertake. This was reflected in the sample of responses quoted below:

*"Patients come in one day, go to theatre the next, and then home the next, and so because they're in such a short time it may get missed."*

*"There's not really much you can do on an acute ward because the stay is so short."*

*"Patients are in hospital only a limited time. Some of that time they're actively ill and the convalescent period is spent at home, and therefore . . . . there's not a lot you can do to actively educate the patient whilst in hospital."*

*"They're gone before we've had chance to teach them very much."*

Such comments may be a reflection of the recent general policy in health care to reduce the length of in-patient hospital stay. As the majority of the ward sister sample had been qualified for over 5 years (see above), it is likely that they would have directly witnessed this reduction over the period of preceding years.

Lack of time to implement health education and health promotion may also be a consequence of inadequate staffing levels, and this was considered influential by 44 (33%) of the sample, as shown in Table 6. Some commented on the changes in nurse education which has meant the withdrawal of student nurses from many wards and a number of those interviewed said that they were below establishment figures. The problem of inadequate numbers of staff are apparent in the following statements from ward sisters:

*"The other thing is the classic one, shortage of staff. We don't have as much time as we'd like to sit and talk, especially with relatives."*

*"We've had a vacancy for ages because of the cash crisis. We have been understaffed for six months now."*

*"I have never known what my establishment is, it's historic. I keep being told I'm over it, but we've never had a formal nursing workload assessment done on this ward."*

Table 6 also shows that "prioritizing care" was felt to exert an inhibitory influence by 40 (30%) of the ward sisters interviewed. This refers to the idea that other care priorities take precedence over health education and health promotion, and is also linked to the belief that lack of time is a barrier to the implementation of these activities. The following comments reflect this theme:

*"Health education would be the lowest on the list of priorities and in what nurses do for patients. It wouldn't be seen as something at all pressing or something that would be included in their care."*

*"Self-caring patients are considered low dependency; nurses concentrate on acutely ill patients, for example those just returned from surgery. They don't want it like this, but it's the way it has to be."*

A final factor cited by the ward sisters linked to lack of time was "workload". Table 6 shows that 26 (20%) of respondents specifically mentioned a heavy workload and the many demands placed on nurses on their wards as interfering with nurses' ability to put health education and health promotion into practice. This idea was exemplified by the following ward sister, who said that:

*"I know nurses always say they are busy and I think they are more and more, and the finer points get cut out if you're not careful, and that would include talking to the patient about his illness and disease."*

This clearly illustrates the perceived relationship between nurses' workload and their ability to put health education and health promotion into practice. Interestingly, "talking to the patient about his illness and disease." is regarded as one of the "finer points" of a patient's

care by this ward sister, which suggests that physical care activities are the priority, in keeping with a medical model of care.

The above findings demonstrate that several of the major inhibitory influences cited by respondents revolved around the issue of lack of time to enable nurses to carry out their health education and health promotion role. Whilst more than one response from a respondent was possible - such that ward sisters could have quoted a lack of time and, for example, inadequate staffing as problematic - the data nevertheless highlight the importance for a substantial number of respondents of sufficient time to practice health education and health promotion. Whilst the demands on nurses' time are undoubtedly very real, and recognized by the researcher, this finding nevertheless suggests that certain beliefs about what it is that nurses should be doing in the name of health education and health promotion are held by these respondents. That is, a belief that there is insufficient time to "do" health education and health promotion suggests that they are regarded as separate care activities, to be added on to "routine" care if there is time, as opposed to a belief that they can be integral components of any interaction with patients or part of a philosophical approach to care, incorporating values such as holism, collaboration and equity (see Cribb and Dines 1993; Macleod Clark 1993). This substantiates the findings presented earlier in this Chapter which indicated that these concepts are regarded as comprising activities such as advice on healthy lifestyles or education about the prevention of recurrence of illness and as such could be construed as relatively separate to other care activities.

However, a minority (n=10 8%) of ward sisters' comments were suggestive of a recognition that health education and health promotion can represent part of an overall approach to patient care. The following comments are indicative of this:

*"On other wards, nurses may see it as something they do when they've got time . . .  
.. here, it is an in-built part of our role."*

*"You have to find time to do things, which can be easy, no matter how busy you are,  
you can still talk to a patient whilst bathing them"*

It is possible that these ward sisters recognized that health promotion can involve the application of certain values or characteristics to any interaction. However, the above comments are ambiguous and none of these respondents referred to values such as collaboration, negotiation or individualized interactions, suggesting that this interpretation should be viewed with caution.

### Lack of patient receptivity

The second most frequently cited difficulty was a belief that patients are not receptive to health education and health promotion. This was considered to be a difficulty by over two thirds (n=88 67%) of the sample, as shown in Table 6, and is again inextricably linked to perceptions about the meaning of the terms “health education” and “health promotion”, as will be discussed below. Lack of receptivity seemed to be related to patients’ reluctance to alter their behaviour, particularly in relation to smoking habits, as the following quotes indicate:

*“We advise patients, we can't tell them, why they should stop smoking and they still do it, so after a while you think what's the point.?”*

*“Age makes it difficult; difficult to break established habits, for example, smoking.”*

Such comments clearly reinforce the finding presented above that, for many respondents, health education and health promotion consist of attempts to persuade individuals to adopt healthy lifestyles, particularly in relation to smoking and diet. Adherence to such ideas will obviously dictate what the ward sisters perceive as barriers to putting health education and health promotion into practice, and this is exemplified here.

Others felt that the acuity of the patients’ illness rendered them unreceptive to advice. One ward sister said that:

*“We have some liver patients in at the moment who are suffering with alcohol withdrawal, so often the first few days is not a good time . . . . but then after four or five days when it may be a good time, they want to go home, so you miss altogether.*  
”

Again, the implication here is that the nurse’s role is to impart advice about sensible drinking habits, with little recognition of the complexity involved in, for example, assessing the patients’ motivation to change, or addressing the wider constraints which may prevent him / her from doing so.

Three (2 %) ward sisters related lack of patient receptivity to individual patient’s preference and/or commonly held expectations about patient and nurse roles:

*“There is a problem with patients not wanting to be involved. For example, some patients at bedside handover will do it themselves, and others will put the newspaper over their face and just don’t want to know anything about it.”*

*“Generally, the public are unsure of what they can and can’t do . . . . I think it’s fear in case they hurt the patient, or that they don’t really know if it’s OK, for example, to help them sit up in bed or get out of bed.”*

*“Some nurses don’t want to educate, they would rather ‘do for the patient’, they like being depended upon.”*

These comments are indicative of a recognition that lay participation in care forms an important component of health education and health promotion and outline some of the issues which surround the achievement of this in practice. However, these and other issues were not mentioned by the overwhelming majority of ward sisters, presumably because encouraging participation in care was not commonly perceived to be a component of the nurse’s health education and health promotion role, as the findings presented earlier in this Chapter illustrate.

#### Lack of knowledge and skill

Table 6 shows that 70 (53%) of the sample considered that nurses lacked the necessary knowledge and skill to enable them to integrate health education and health promotion into their practice. The particular types of knowledge and skill deemed lacking by these ward sisters sheds further light on their perceptions about the meaning of health education and health promotion and of nurses’ role in implementing them. Many ward sisters who cited lack of knowledge as an inhibitory influence implicitly referred to lack of knowledge about the subject or content of the health education message, as the following quotes exemplify:

*“If anything, it’s a lack of knowledge about health education issues . . . . there’s no barrier from a management point of view. If they don’t incorporate it into their care it’s due to lack of knowledge.”*

*“We have quite a few newly qualified staff nurses who don’t have the confidence of the senior staff and are not sure they’re saying the right thing.”*

*“More knowledge, as well, would help. You’re not actually told how to do things. It’s hit and miss, learning as you go along, picking things up from the various parts and making a whole. Maybe the odd study day on these things would help.”*



*“No, there’s not sufficient knowledge .....there’s always a risk that nurses will give the wrong information.”*

*“Sometimes I feel I lack knowledge as to what I should say to relatives and patients.”*

Interestingly, two of the above ward sisters suggest that this type of substantive knowledge about the content of the health education message is acquired by virtue of experience. Thus one respondent felt that it is the “*newly qualified staff nurses* “ who are not sure they are saying the right thing and that another stated that it’s “*learning as you go along*” . Other responses also contained reference to the idea that more senior staff had greater knowledge than those more recently qualified. It might be hypothesized that the understanding of health education and health promotion philosophy and knowledge and skills that could be acquired by time spent in an acute ward setting would be limited in comparison to formal educational input similar to that received by student nurses currently on Project 2000 courses. This therefore also suggests that perceptions about what constitutes health education and health promotion are limited to a somewhat simplistic process of information-giving which can be “picked up” by virtue of experience.

Other comments in this category referred to nurses’ lack of skill in imparting the health education message:

*“Some of the staff do shy away from educating patients. I think it’s because they don’t know how to put it across in such a way that it will be taken on board or even listened to.”*

*“The difficulty comes from people not having enough training and advice on how to give information.”*

*“We sometimes have problems explaining things to patients. You may know what you want to say, but can’t get it out in a way that they will understand. This can sometimes confuse them more.”*

These comments reflect a recognition of nurses’ lack of skills in relation to health education. Whilst the types of skills believed to be lacking are not directly evident from these remarks, in the context of findings presented else where in this Chapter, it is likely that the ward sisters may have been referring to those needed to persuade or coerce patients into accepting the health advice offered. That is, none of the respondents mentioned lack of knowledge or skill in relation to nurses’ ability to empower patients, help them acquire

lifeskills or foster self-esteem as inhibitors to current practice. Interestingly, in view of the ward sisters' lack of recognition of the concepts inherent in the new paradigm approach to health education and health promotion, none of the respondents cited lack of knowledge about what the concepts themselves represent as an impediment to practice, suggesting a lack of insight in this respect.

#### Interference with patients' freedom of choice

The final inhibitory factor identified by the ward sisters to be considered here is that of interference with patients' freedom of choice. This was considered to be a difficulty by 17% (n=22) of the sample and refers to the idea that the implementation of health education or health promotion would be seen as impinging on a patient's liberty and / or quality of life. Once again, the data indicate that opinions about inhibitory influences on practice are underpinned by the ward sisters' interpretations of the meaning of the concepts of health education and health promotion. Thus, many of the responses in this category reflected a pre-occupation with individualistic and prescriptive lifestyle advice - particularly in relation to smoking habits. The responses below are illustrative:

*"We don't use every opportunity that's there . . . . because some nurses probably see it as interfering with the patient's own liberty. I find it very hard myself to say, 'you shouldn't smoke' when their quality of life is really bad, or that 'you shouldn't eat something' when they're ninety."*

*"If we have a patient who is a smoker, we will try very hard, but at the end of the day you have to allow individual choice."*

*"It depends on the age and diagnosis of the patient, with some elderly patients . . . . those with chest conditions . . . . it's not right to give them advice about smoking . . . . you must consider their quality of life too."*

Clearly, interfering with a patient's liberty or freedom of choice is only an issue if advice or information is given in a judgemental or prescriptive manner - characteristics that are not representative of the new paradigm approach to health education and health promotion, as outlined in Chapter One. Presumably, if these ward sisters were operating with ideas about health education which emphasizes a two-way communication process which seeks to empower patients, and at the same time recognizes social and political constraints to freedom of choice, then "interference with patients' freedom of choice" would not be a difficulty. In fact, analysis of responses to this item revealed that only 11 (8%) ward

sisters cited social and economic influences as problems encountered by nurses attempting to put health education and health promotion into practice. Thus, one ward sister said:

*“When I was working in X District Health Authority I was very aware that there were so many things that were environmental . . . . housing, unemployment, low wages, social isolation. I think this is a big problem.”*

The majority of respondents however, did not appear cognisant of the barriers imposed by these structural influences on health, and the consequent need to address these within a health education interaction.

Overall, the data that emerged when respondents were asked to describe the difficulties that nurses faced in attempting to put health education and health promotion into practice reinforce findings presented earlier in this Chapter. The difficulties identified shed light on these nurses’ interpretations of health education and health promotion and what they feel it is that they should be doing in it’s name. The findings give substance to the idea that these nurses were operating with ideologies that equate with the traditional or behaviour change approach to health education and that they were not familiar with the concepts inherent in the more recent theoretical literature.

### Facilitating Factors

As stated above, ward sisters were also asked to identify factors which they believed either currently help, or would help, nurses to integrate health education and health promotion into their practice on their respective wards. Selected findings from analysis of responses are presented below. The data give a further insight into the way in which the concepts of health education and health promotion and nurses’ role in this are interpreted and also illuminate what were subsequently found to be some potentially important influences on this aspect of nurses’ practice at ward level. The latter are returned to in the light of the findings from the case study wards presented in Chapter Five.

Table 7 shows both the current and potential facilitative influences on nurses’ health education and health promotion practice as identified by the ward sisters.

Relevant findings from these categories are presented in turn below.

**Table 7: Factors facilitating health education and health promotion practice cited by ward sisters**

| <b>Factors identified by ward sisters</b> | <b>Current facilitating factors</b> | <b>Potential facilitating factors</b> | <b>Total</b> |
|---|-------------------------------------|---------------------------------------|--------------|
| Health education resources                | n=53 (40%)                          | n=19 (14%)                            | n=72 (54%)   |
| Nurses' characteristics                   | n=43 (32%)                          | n=1 (1%)                              | n=44 (33%)   |
| Organization of care                      | n=40 (30%)                          | n=6 (4%)                              | n=46 (34%)   |
| Patient receptivity                       | n=37 (28%)                          | 0                                     | n=37 (28%)   |
| Philosophy of care                        | n=25 (19%)                          | n=4 (3%)                              | n=29 (22%)   |
| Nurses' knowledge                         | n=21 (16%)                          | n=1 (1%)                              | n=22 (17%)   |
| More time                                 | n=18 (13%)                          | n=13 (10%)                            | n=31 (23%)   |
| Staff development and training            | n=18 (13%)                          | n=7 (5%)                              | n=25 (18%)   |

A number of the factors identified (that is, nurses' characteristics, patient receptivity, nurses' knowledge and more time) are the exact opposite of the counterpart inhibitory influence. For example, patient receptivity referred to patients who were perceived as willing and able to change their health related habits such as their smoking behaviour. Nurses' knowledge was cited by those who felt that nurses had sufficient knowledge to enable them to put health education and health promotion into practice. As these findings have been examined above, they are not explored further here.

#### Health education resources

Table 7 shows that 40% (n=53) of the sample identified the health education resources currently available on the ward as a facilitative influence, whilst 14% (n=19) felt that it would be helpful if such resources were to be available to nurses on their wards. The types of resources referred to most commonly included leaflets or booklets to give to patients on a wide range of topics from sensible alcohol intake to coronary rehabilitation and cervical screening. Whilst these resources may undoubtedly be useful in reinforcing certain types of health education advice, the frequency with which they were identified may be congruent with the predominant interpretation of health education as merely information-giving about prevention of illness and / or lifestyle-related issues. And, as the findings from the case study wards demonstrate in Chapter Five, although leaflets and posters may be a useful adjunct to nurses' practice, their availability and prevalence on a ward is by no means a indicator of the extent of health education and health promotion practice occurring on that ward.

#### Organization of care

A second facilitative factor, cited by 30% (n=40) of respondents, was the method of organizing nursing care on the ward. This refers to the way in which nursing work is allocated to individual nurses or groups of nurses and includes primary nursing, team nursing, daily allocation of patients and task allocation (see Pearson 1988). Of those who cited the organization of care as a current facilitative influence on health education and health promotion practice, 98% (n=39) stated that they were practising either primary or team nursing on their wards (35% (n=14) primary nursing and 63% (n=25) team nursing). These systems of organizing care were considered to be facilitative via a number of processes. Firstly, primary and team nursing were felt to enhance individual nurses' responsibility for a patient's care, thereby making them more likely to consider their own personal responsibility for health education. This is reflected in the following comments:

*“Primary and associate nurses know that they are ultimately responsible for the care that their patients receive, and so they take on the responsibility of health education.”*

*“Nurses say that since primary nursing they find themselves going to look things up because they know it’s their responsibility to explain to the patient”.*

Whilst another ward sister's comment illustrated the potential advantage of adopting a system of primary nursing in terms of its influence on nurses' responsibility for their patients' care, and thus health education:

*“We don’t have a system of primary nursing where one nurse is responsible for one patient’s teaching. If we did, it would be done in a better way. But at present it’s everybody’s job and nobody’s job.”*

Such comments are clearly indicative of how enhancing responsibility for care may facilitate health education. Primary and team nursing were also felt to result in improved nurse-patient relationships, and this was also considered beneficial in several ways, as reflected in the following quotes from a number of different ward sisters:

*“Team nursing means we can develop therapeutic nurse-patient relationships which makes it easier for patients to ask difficult questions.”*

*“A trusting relationship with all nurses means the patient is more likely to believe what you are saying. It’s not just because you’re a professional, but because you care about what’s best for them and therefore the message has more meaning.”*

*“Primary nursing means you get to know the patient’s social background, and therefore problems and advice can be dealt with in a more realistic way. This is to do with relationship building; the knowledge and trust that results from primary nursing.”*

The latter ward sister was unique in her identification of the patient's social background as influential in the advice-giving process and indicates a recognition of the broader, structural influences on health which the majority of other respondents failed to recognize.

Thus, the development of a therapeutic relationship, based on mutual trust was felt by these ward sisters to enhance nurses' health education practice. Related to this, the

continuity of care provided by these systems was also seen as beneficial. This idea is exemplified by one respondent, who said that:

*"You can't do health education on an ad hoc basis with a different nurse every shift. Continuity and good nurse-patient relationships are pre-requisites for good health education."*

The increased accountability and autonomy that results from primary or team nursing was also identified as facilitative. One ward sister expressed the view that:

*"Primary nursing is not just an allocation system, when its used in the right way it gives the opportunity for a whole new way of working. If nurses understand accountability and take the relationship seriously, it transforms practice."*

Organizing care via a system of primary or team nursing was also felt by some of these nurses to increase nurses' autonomy for the provision of their patients' care in that individual nurses assume responsibility for decision-making on a daily basis as opposed to being instructed by the ward sister about what to do. This could be expected to have an empowering effect on the nurses involved, and is a point returned to in Chapter Six.

Thus, the system of organizing care on a ward was considered by approximately one third of the ward sisters, who were practising primary or team nursing, to enhance nurses' health education practice. Team or primary nursing were felt to be associated with a number of favourable features- responsibility, continuity, improved nurse-patient relationships, accountability and autonomy - which were thought to be conducive to health education at ward level. However, it is unclear as to the reason why these factors were regarded as facilitative. That is, was it because they allowed nurses to more effectively persuade patients to take up their advice about illness prevention or healthy lifestyles (in keeping with their perceptions about health education and health promotion outlined earlier in this Chapter) or because they facilitated activities such as participation and empowerment of patients? In view of the findings presented elsewhere in this Chapter, the former interpretation is more likely. The influence of organization of care is returned to in Chapter Six in the light of the findings from the case study wards.

Associated with the theme of organization of care, three ward sisters (2%) stated that their style of management was helpful to health education practice. These ward sisters

felt that their management of ward staff was characterized by a non-hierarchical, democratic style which encouraged autonomy and responsibility. One said:

*"We're getting rid of the rubbish to do with hierarchical nursing, for example starchy hats and tights. We try to get away from treating people like school children instead of thinking adults. It's detrimental to getting nurses to think for themselves and to develop skills to teach other people."*

And another:

*"I have tried to implement a new structure on the ward.....it was a hierarchical, task-oriented ward; it is now a democratic, thinking ward where the nurse is given much more responsibility and authority to practice.....once you expect nurses to be proactive, they will be."*

This idea was an important finding to emerge from observation of nurses' practice on the six case study wards and is explored further in Chapters Five and Six.

#### Philosophy of care

In response to this question asking ward sisters to describe factors facilitating nurses' health education and health promotion practice at ward level, 22% (n=29) stated that the existence of a certain philosophy of patient care which was shared by nursing staff was important. Of these, 19% (n=25) felt that the current philosophical approach to care in operation was beneficial, and 3% (n=4) considered that a different philosophical approach would have the potential to improve nurses' health education and health promotion practice (see Table 7). A flavour of some of the central tenets of such a philosophy are given by the following quotes:

*"It comes back to our philosophy, which is that people have choices, and if they're going to make a choice about something, they need information."*

*"...because of our philosophy of nursing, we aim to make partnerships with patients and to agree their care with them. It's holistically based."*

*"Patient participation is part of the ward philosophy, and if you don't agree with that, then you don't work here."*



These comments suggest that the ward sisters who felt that a certain philosophy of care was important had a more sophisticated understanding of the nurse's health education role and the influential factors enabling nurses to implement this. That is, reference is made to important health education concepts such as holism, participation and partnership by the above ward sisters. In addition, citing philosophy of care as important is suggestive of a recognition that part of the nurse's health education and health promotion role consists of a certain approach to any nursing activity in addition to implementing certain key activities such as information-giving and education. The implicit suggestion is that health education and health promotion cannot be a feature of nurses' practice unless there is a conducive underlying framework or philosophy in place at ward level. Although the philosophy of care was identified by only a comparatively small number of respondents as influential (in comparison to those who identified resources as important, for example) data derived from the case study wards indicated that in practice, the philosophical approach to care was related to nurses' health education and promotion practice. This idea is therefore re-visited and explored in the light of the case study ward findings presented in Chapter Five .

To summarize, selected findings from an item asking the ward sisters to describe factors that either currently or potentially would help nurses put health education and health promotion into practice have been presented above. Many of the responses were a reversal of the inhibitory influences outlined previously by the ward sisters and are thus congruent with the ideas that they appeared to be operating with presented earlier in this Chapter. The finding that health education resources such as leaflets and booklets were the most commonly identified facilitator of nurses' practice also suggests that the nurse's role is predominantly perceived to be about information and advice-giving in a somewhat simplistic manner. Nevertheless, other interesting findings did emerge in response to this question. A minority of respondents cited primary or team nursing and / or a certain philosophical approach to care as important facilitative influences. The latter two influences were found to have important implications for the nurse's role in health education and health promotion from data derived from the case study wards and are discussed further in Chapter Six.

Once again, the types of facilitating factors identified by the majority of ward sisters illustrate their pre-occupation with the individual nurse-patient level of operation of health education. For example, none mentioned ways in which multi-sectoral planning on local issues affecting health or the implementation of hospital health enhancing policy was or could be facilitated. This reinforces findings presented elsewhere in this Chapter and indicates again that the policy level at which health promotion is believed to

operate is not a feature of nurses' understandings about these concepts or their perceptions about their role as nurses in health education and health promotion.

### **Summary**

In conclusion, this Chapter has presented the findings from the ward sister interviews pertaining to nurses' perceptions of health education and health promotion and nurses' role and practice of these activities at ward level. Whilst a number of different facets of the interview responses have been explored, several main themes underpinning all of these emerge. That is, respondents have a limited understanding of what the concepts of health education and health promotion represent. Consequently, their ideas about nurses' role in these activities are also restricted.

More specifically, their interpretations were characterized by an orientation towards prevention of physical illness as opposed to the promotion of positive health. In addition the majority of respondents focused on tertiary, as opposed to primary preventative advice and few emphasized mental or social components of health. Responses were also characterized by an emphasis on individualistic information-giving or lifestyle advice indicative of a reductionist perspective towards health education and health promotion. The findings indicate that there was little recognition by respondents of the essential two-way or collaborative nature of the information-giving process which is considered a hallmark of effective health education. There was also a lack of recognition by these nurses of the wider, structural determinants of health and health-related behaviour. Related to this, almost all of the respondents failed to recognize the broader, or policy level at which most commentators suggest health promotion operates. Also absent was any recognition of important concepts such as participation, equity and the inter-sectoral nature of health promotion work. The findings also show that the overwhelming majority of nurses seem unaware of concepts and principles inherent in the self empowerment model or a new paradigm approach to health education. Thus, although many mentioned information-giving and patient education as part of the health education role of nurses, they did not view this as a potential vehicle for empowering patients. Only a small minority of ward sisters appeared cognisant of some of these elements, and in some instances, this was linked to recent post-registration education. In addition, other findings about factors perceived to facilitate health education at ward level are suggestive of a more comprehensive understanding held by a minority of the nurses.

However, the findings indicate that the majority of the interview sample had limited understanding of the concepts of health education and health promotion and nurses' role in this. It is suggested that one way of illustrating these findings is to conceptualize a developmental continuum which depicts the range of sophistication and comprehensiveness of perception possible. Clearly, the nurses' perceptions derived from the interviews in this study can be located at the least well developed extreme of such a continuum. This idea is explored further in Chapter Six in the light of findings from the case study wards.

The perceptions held by these nurses about what the concepts of health education and health promotion represent and their role in this have important implications for nurses' ward based practice of these activities. The importance of observing the reality of nurses' practice in addition to the collection of self-report data and examining the relationship between the two has previously been commented on (see Chapters Two and Three). Thus the findings concerning the reality of nurses' health education and health promotion practice derived from data collection on three wards employed as case studies are presented in the following Chapter.

**CHAPTER FIVE**  
**NURSES' HEALTH EDUCATION AND HEALTH PROMOTION**  
**PRACTICE: FINDINGS FROM THE CASE STUDY WARDS**

**Introduction**

As discussed in Chapter Three, a sub-sample of three case study wards was selected from the ward sister interview sample in order to collect data on the day-to-day reality of nurses' health education and health promotion practice. The aim of the sampling procedure employed was to maximize the possibility of selecting wards on which good health education and promotion practice was considered to have developed. A multi-method approach to data collection was employed in order to describe and explain nurses' health education and promotion practice and to highlight its relationship to nurses' perceptions about the concepts and their role. On each of the case study wards data were collected using self-administered questionnaires to ward-based nursing staff, non-participant observation of nurses' practice, tape-recorded nurse-patient interactions, and field notes made daily by the researcher. A protocol was also designed and utilized in order to standardize and guide data collection on each of the individual wards (see Appendix 5).

Findings from each of three individual case study wards are presented and this is then followed by a summary of the findings as a whole in order to highlight differences and similarities in nurses' practice and offer explanations about the major influential factors involved.

**Health Promotion in Nursing Practice: Findings From Individual Case Study Wards.**

**Ward 1**

**Background**

Ward 1 is located in a large teaching hospital situated in an ethnically diverse neighbourhood characterized also by areas of social and economic deprivation. Attached to the hospital is a large College of Nursing which has a Project 2000 curriculum in operation for pre-registration student nurses.

Ward 1 is a 30-bedded mixed acute general medical ward with oncology and diabetic specialities. The ward has a high proportion of emergency admissions and a smaller number of routine, planned cases; patients' average length of stay on the ward at the time of data collection was 7.3 days. Patients' ethnicity reflects the locality in which the hospital is situated with many Afro-Caribbean and some Asian patients as well as Caucasians. Analysis of the nursing records of a random week of admissions revealed that the mean age of patients admitted to Ward 1 was 55 years.

Analysis of data was also undertaken to reveal the staffing profile of the ward at the time of data collection. Staff working on Ward 1 comprised:

- 1 senior sister
- 1 junior sister
- 2 senior staff nurses
- 15 staff nurses
- 2 enrolled nurses
- 4 third year nurses
- 8 auxiliary nurses (including part-time and night staff)
- 2 health care assistants.
- 1 part-time ward receptionist

The annual budget for staff in 1991 available to Ward 1 was £497,612 and at the time of data collection the staffing level was up to its establishment .

Analysis of biographical data provided by staff who completed self-administered questionnaires (n=12 52%) revealed further information about the staff (see Table 8). Of the qualified staff completing questionnaires, all had been employed on the ward for less than 18 months, with a mean of 11.4 months. Questionnaire data also revealed that the nurses' level of further and/or post-registration education was minimal: none had obtained a degree or any other health education or health promotion-related courses – the only qualifications mentioned were one diploma and three ENB-approved courses by three separate staff nurses.

**Table 8: Biographical characteristics of nurses returning questionnaires on Ward 1.**

|                                    |   |
|------------------------------------|---|
| <b>Q'res distributed</b>           | n=23  |
| <b>Response rate</b>               | n=12 (52% )   |
| <b>Grade/position</b>              |   |
| Student nurse                      | n=2   |
| Enrolled nurse                     | n=1   |
| Staff nurse                        | n=3 (D grade)<br>n=1 (E grade)<br>n=3 (unspecified) |
| Senior staff nurse                 | n=2 (F grade)                                       |
| <b>Length of time on ward:</b>     |   |
| <b>Range</b>                       | 2-18m   |
| <b>Mean</b>                        | 11.4m   |
| <b>Qualifications:</b>             |   |
| ENB course                         | n=1   |
| ENB 998                            | n=2   |
| C&G 730                            | 0   |
| Cert. Ed.                          | 0   |
| Nursing Diploma                    | n=1   |
| Nursing Degree                     | 0   |
| <b>Length since qualification:</b> |   |
| <b>Range</b>                       | 4m-11 years   |
| <b>Mean</b>                        | 3years4m  |

Nursing care of patients was organized by the ward sister or most senior nurse on duty who was 'in charge' for that shift. Nurses were allocated individually or in pairs to certain geographical portions of the ward on a daily basis. The nursing handover at the beginning and end of shifts took place in the ward sisters' office and was given entirely by the person 'in charge' to the oncoming staff. This was then followed by a bedside handover from individual nurses who had been allocated to that area/ those patients for that shift. Nursing care plans were kept in folders at the end of each patient's bed, whilst the admission sheet with details of the patient's history, etc; was kept at the nurses' station in the centre of the ward.

Data were also collected about the health education and health promotion resources available to nurses on Ward 1. The vast array of health education and health promotion literature posted up around the ward was immediately apparent on entering the ward, with nearly all available and appropriate wall space being filled by posters and/or leaflets conveying health education or health promotion messages. A total of 43 posters were on display at the time of data collection on subjects ranging from nutrition and alcohol to women's health issues and how to make a complaint about your General Practitioner. A number of these had been designed by ward staff, whilst others came from sources such as the Milk Marketing Board, the British Heart Foundation and the Action for Dysphasic Adults organization. A plethora of leaflets was also in evidence; these were displayed in a large rack and on shelves in a central position, and were mainly concerned with the topic of heart health and healthy habits such as diet and exercise. Analysis of factors spontaneously mentioned by those returning completed questionnaires suggests that these resources were considered important by staff in helping them fulfil their health education role. Fifty-eight percent ( $n = 7$ ) stated that they were a facilitator of their health education and health promotion practice.

Other resources available to the nurses on Ward 1 included a range of specialist personnel with links to the ward such as diabetic health visitors, a Macmillan nurse and a stoma care sister.

### Data Collected

Data were collected on Ward 1 over a four week period. Of the 23 members of staff who were given self-administered questionnaires, 12 (52%) returned these during the data collection period (see Table 8). Tape recordings were made of seven different incidents on the ward, comprising one office and two bedside handovers, three patient admissions and a drug round by the ward sister. Seven two-hour observation periods were undertaken, covering different time periods of the day, ranging from early morning to early evening; reflective field notes were made daily, following many unrecorded observations or interactions witnessed by the researcher. During the first few days on the ward, more informal observation, centred around 12 different incidents, was also conducted and field notes made on these. These comprised: four office handovers, three bedside handovers, one admission, two drug rounds and two doctors' ward rounds.

Findings from the various sources of data collection are described below.

### Nurses' Perceptions of Their Health Education and Health Promotion Role

The questionnaires yielded data concerning nurses' perceptions about their role in health education and health promotion. The process of content analysis enabled predominant themes about nurses' ideas to emerge. Three main activities were identified in this way. The most commonly cited role, identified by 9 (75%) of nurses on Ward 1, was that of generally giving advice. Six (50%) of these nurses specified that this health education role involved advice about lifestyles. Example comments included:

*"We (also) spend some time educating cardiology patients regarding their diet and smoking."*

*"Advising, e.g. dietary intake or personal hygiene."*

Related to this idea, a smaller proportion (n=5 42%) of comments concerned the nurse's role as that of a teacher:

*"To teach patients about their illnesses, so that they understand their conditions"*

*"I have a major role as a health educator: to give the patient teaching and ensure his understanding about his condition."*

Thus it seemed that nurses on Ward 1 perceived their role to be one of giving advice and teaching individual patients. However, there was little indication of a recognition of some of the concepts believed to be central to this - for example, the need for advice to be individualized and to involve collaboration between the nurse and patient. None of the nurses mentioned empowerment or patient participation in the context of this question, suggesting that this did not form part of their understanding of their health education role. In addition, none of the respondents commented on a role for nurses in health promotion, that is, beyond the domain of working with individuals. Overall, this suggests that these nurses' perceptions about their role were rather limited and simplistic.

However, when specifically asked about influencing hospital health promotion policy, 11 (92%) of the respondents on Ward 1 considered that this was a part of their role. When asked about ways in which they might do this, a range of suggestions were offered. For example, two nurses felt that this was best done through canvassing and presenting patients' opinions on relevant policy matters, whilst two other comments pertained to the need for nurses' involvement in multi-disciplinary meetings. The need for nurses to be



involved in committees to achieve policy change was commented on by two of the nurses and another felt that working through nurse line management would enable nurses to fulfil their role in this respect. This suggests that these nurses did possess ideas about their role which were relevant to health promotion, although they perhaps did not explicitly perceive this as health promotion work (as evidenced by the lack of spontaneous reference to such activities in their responses to the initial questionnaire item).

In response to this question then, it seems that the nurses did perceive a role for themselves in health promotion policy change. They were also able to identify mechanisms by which they could exert an influence on these within the hospital environment. Some of the responses were congruent with health promotion principles, such as lay participation and advocacy (canvassing and presenting patient opinion) and multi-agency working. However, no examples of this nature were found in practice and it appeared that despite nurses' favourable opinions, they had not yet begun to develop their role in this respect (see below). This finding is discussed further in Chapter Six.

#### Nurses' Health Education and Health Promotion Practice

On completion of data collection on Ward 1 the researcher felt subjectively that a useful overall impression of the extent of nurses' health education and health promotion practice and the major influencing factors involved had been gained. This was confirmed when the data were analyzed: separate periods and incidents of data collection revealed similar findings and the different data sources verified each other with regard to the central research questions which the research aimed to address. Overall, the data revealed that health education and health promotion activities were generally lacking from nurses' practice, and their role in this respect remained poorly developed. Both non-participant observation notes and recorded interaction data revealed that the only way in which health education could be considered present was via some minimal information-giving to patients, the quality of which appeared to be variable and which, in many instances, represented aspects of the traditional medical model-derived approach to health education. This information-giving was often instigated by patients rather than nurses – and there was an absence of other health education activities such as patient education and lifestyle advice about health and illness issues as well as encouraging lay participation in care. Interactions did not accord with health promotion values and characteristics as outlined in Chapter One. In addition, there was no evidence of nurses' involvement in health education and health promotion activities away from the bedside or one-to-one approach through, for example, group work or involvement in health promotion policy formation. Specific details and examples to illustrate these findings are presented below.

### Minimal information-giving

Analysis of non-participant observation notes allowed conclusions to be drawn about the types of activities and interactions that nurses were engaged in with patients on Ward 1. These revealed that there were often extensive periods when no nurse-patient contact was observed; interactions that did occur appeared to take place as a result of the nurses' need to complete a physical care task such as the need to change a patients' position or administer a medication. The majority of these types of interactions did not contain evidence of any health education advice being offered to patients – rather, patients were asked questions, given instructions or engaged in social chat. For example, patients were asked what they had had to drink so that the nurse could complete the fluid balance chart, or advised that they should take the medication which the nurse had placed in front of them.

Observation notes revealed that the only type of health education activity occurring was information-giving to patients. This was often minimal, and amounted to no more than a 'commentary' on what the nurse was doing or about to do with a patient – for instance, change a sheet or prepare the patient for a wash. It is in fact arguable whether the nurse would have been able to carry out some of these tasks without informing the patient, in that the information was given in order to obtain the patient's co-operation, indicating that the giving of information was for practical purposes as opposed to philosophical reasons, such as patient choice and control. Some evidence of information-giving about medication was also noted, although this was usually restricted to naming the tablet (e.g. Erythromycin) and its function (e.g. antibiotic). In addition, there were one or two examples of patients being given information about their treatment or plan of care, such as when the doctor would be round to see them or when they were likely to be discharged home (see below).

The recording of observations made by the researcher revealed that the information given by nurses amounted to no more than cursory advice. No serious attempt was noted to assess individual patients' health education needs or engage in a dialogue about a patient's health by any of the nurses.

Analysis of the tape-recorded interactions confirms the above findings and sheds further light on the style of the information-giving observed. The recorded interactions also revealed that the development of nurses' health education practice was confined to information-giving to patients; again, there was no evidence of other health education activities such as patient education, healthy lifestyle advice or encouragement of patients and their families to participate in care. The extensiveness and style of this information also

appeared to vary: examples indicated that the information given was minimal, as the following excerpt shows:

N8 (1): *"So the only tablets you're on is the Ranitidine. Which doctor did you see last time, was it Dr Xxx?"*

P: *"Yes, Dr Xxx, yes."*

N8 (1): *"She's away at the moment, so it's Dr Xxxx – will be coming to see you."*

P: *"Don't know him."*

N8 (1): *"She – it's a lady doctor, she'll actually – she's actually doing a locum job, and I think she's on the ward round at the moment and then she'll be coming, so she will get to you at some time"*

(Taped admission)

The examples of information-giving contained in the recorded interactions also varied in relation to the style of the information-giving process or the level of skill utilised by the nurse in transmitting the information. The following excerpt is indicative of a lack of skill in relaying information which is presumably designed to allay the patient's anxiety, rather than increase it, which may have been the net result of this interaction:

N11 (1): *"And you'll probably feel very, very sick – probably while you're having chemotherapy and maybe after, a few hours after, you will feel very nauseated, and you'll feel like vomiting."*

P: *"That's –"*

N11 (1): *"You might."*

P: *"Yes."*

N11 (1): *"But most likely that you'll feel quite sick and you'll feel like vomiting quite a lot, and you'll feel quite down."*

P: *"Yes. Oh."*

N11 (1): *"I think to watch out really is while you're having chemotherapy is to just – for us to just come and check your arm regularly because it's such a toxic drug. All chemotherapy drugs are such toxic drugs that we'd need to constantly check what your – your site was like, just in case you do have a reaction. Plus if it does become inflamed, or very sore and red, it could mean that it's not going directly into your system but it's actually going into the tissues. And you've got to be really careful because it could end up being a big blister on your arm."*

(Taped admission)

This indicates that although the nurse was giving information to the patient, the interaction was not carried out in a manner which would encourage the patient to feel empowered as a result. The individual patient's needs are not addressed and ways in which the patient might manage the unpleasant sensations to be expected are not explored by the nurse. Thus, although the patient is in possession of more information, she is not necessarily in a position of greater control. This illustrates, as suggested in Chapter Two, that information-giving *per se* is not in itself empowering - rather, it is dependant on the manner and skill with which it is delivered. The above excerpt typifies a number of examples of information-giving recorded in that it is characterized by a one-way communication process dominated and led by the nurse, with the patient confined to a passive role as listener.

One nurse's communication did seem to reflect a more skilful, knowledgeable approach to offering a patient information in preparation for an impending nerve-block (see Appendix 9). A subsequent evaluation by the nurse of the effects of the information given demonstrated that it did seem to have had a beneficial outcome, allaying the patient's fears, as the following excerpt illustrates:

N10 (1): *" . . . . they keep taking different pictures as they go along, so they know they're going into the right place. OK?"*

P: *"Lovely, yes. I can sleep tonight now."*

N10 (1): *"Nothing to worry about."*

P: *"Might get some sleep."*

N10 (1): *"Has that eased your mind a little bit?"*

P: *"Yes, it has, a little bit, thanks. You see, you say what I don't know I don't grieve, but what you imagine can make it worse, can't it?"*

N10 (1): *"Yes. Your mind can play havoc with you."*

(Taped admission)

Nevertheless, this example was exceptional and not representative of the majority of the interaction data collected on Ward 1. It is possible that this particular nurse had greater knowledge, skill and / or a different approach to patient care than the other nurses, although analysis of this nurse's biographical characteristics provided by the questionnaire data give no obvious reason why this should be so. Most instances of information-giving were minimal and/or poorly executed, and it is questionable whether they could in fact be considered to be examples of 'health education' at all in the light of current understanding about the constituent elements of this activity.

#### Lack of patient participation

Analysis also revealed that information was often sought by patients rather than spontaneously offered by nurses, and patients often expressed a desire to participate in their care despite, rather than because of, nurses' communications. The following excerpt suggests that the patient wishes to participate in his care, and yet this is ignored by the nurse:

N 1 (1): *I think we're just going on to test your urine. X explained about testing the urine, didn't she?"*

P: *"I normally do that at home."*

N 1 (1): *"You do that at home."*

P: *"Yes."*

N 1 (1): *"Fine."*

P: *"I do that at home."*

N 2 (1): *"Right, OK. So we'll be doing that twice a day now."*

(Taped bedside handover)

This clearly illustrates that the idea of patient participation is not on this nurse's agenda, and the way in which the nurse assumes responsibility for a self-care activity normally managed by the patient is in direct contrast to basic health education and promotion principles which emphasize collaboration and participation. This finding was also validated by analysis of the researcher's observation notes which indicated a general lack of patient participation in care. Despite the previously mentioned poster detailing how patients could make a complaint to their General Practitioner, no other evidence was collected of patient involvement in the way in which care was delivered, either at a policy or individual level. For example, patients' fluid and food charts as well as their care plans were observed to be completed by nurses when there was no obvious reason why patients themselves could not have done this, or, in the case of care plans, why they could not have collaborated with nurses in doing so.

#### Approach to patient interactions

Analysis of a number of recorded patient admissions and nursing bedside handovers allowed overall statements to be made about the pattern and characteristics of these interactions. Analysis of the patient admissions revealed that, in addition to a lack of health education, nurses' communication seemed to be oriented almost solely around the questions on the admission form, without exploration of the patient's agenda. This resulted in abrupt changes of subject as the nurses moved from one question to another and the seeming collection of information for information's sake, without any attempt to deal with this information. This obviously also prevents opportunities to engage in health education with the patient. The following example, taken from a patient admission, exemplifies this:

N8 (1):       *"When were you first diagnosed as having lymphoma?"*

P:               *"It was suspected....."*

Wife:         *"2nd September."*

P:               *"2nd September, and confirmed shortly after that."*

Wife:         *"The 11th."*

N8 (1):       *"Oh right, so it's been fairly recent."*

P: *"Oh yes, yes. It's not all that.... it's happened fairly quickly. And then we were referred to the oncology clinic here."*

N8 (1): *"Yes. Right. Are you allergic to any drugs or anything that you know of - any elastoplast or anything? No?"*

P: *"I don't think so."*

N8 (1): *"Are you on any tablets at the moment?"*

Wife: *"Ranitidine - two at night."*

(Taped admission)

Analysis of recorded bedside handovers also revealed that these were characterized by a lack of health education, or health education and promotion principles. The researcher's observation of these handovers revealed that they generally took place at the bottom of the bed and both observation and recorded material indicated that frequently patients were not included or that their inclusion was confined to a few words to confirm what the nurse had said. Communication was also confined to details of physical care only, with little attention to the patient's psychological or social needs – a finding that is characteristic of a medical model approach to care. The following excerpt is indicative of this:

N 1 (1): *"Her major problem this morning has been her hearing aid. X (nurse) has worked extremely hard sorting out her hearing aid and it's now working. And she's not shouting at us any longer. Her blood sugar – she's a – no, she's an insulin-dependent diabetic and her blood sugars are quite stable. She's been weighed and her weight's remained much the same. She's still got to have continuous oxygen because she remains quite breathless and . . . . on her bottom she's got some Granuflex, yes, and her bottom's very sore as well. And we're standing her up and she's been in bed – she was in bed about an hour?"*

P: *"About a half-hour."*

N1 (1): *"About half an hour. And then has got out again – she prefers sitting out in the chair but it is giving her bottom problems so she'll have to get back in again, I think this afternoon, or on the side. We could try."*

N2 (1): *"Is that still the same Granuflex from yesterday?"*

N1 (1): *"Yes . . . . X it was, wasn't it?"*

N 3 (1): *"Yes."*

N 1 (1): *"Yes."*

(Taped bedside handover)

This excerpt exemplifies the way in which nurses focused on the physical care of the patient and talked over and excluded her from the interaction, thus making it likely that this had a disempowering effect on her. The bedside handovers were characterized by the patient being forced into a passive, submissive role whilst the nurse dominated the interaction. Obviously such an approach results in a hierarchical interaction between 'expert' and 'non-expert' and is the antithesis of a health education approach in which collaboration, equal participation and empowerment are paramount. A second excerpt illustrates these findings:

N2 (1): *"Mr X has oedematous feet . . . . it's still sore now and then. The majority of the time he's been sitting down here, while he was on the ward. He went off to get his barium enema today and hence the reason . . . ."*

N1 (1): *"He's not keen to keep them up at all."*

N3 (1): *"He finds it really difficult, don't you, keeping your legs up?"*

N1 (1): *"I know, he's fed up with me. . . . I'm sorry."*

N2 (1): *"He went off to get his barium enema today, and he's much better now. He's going to eat and drink. He didn't really have anything much today."*

(Taped bedside handover)

Once again, the nurses talk over the patient and he does not contribute to the interaction, although the researcher's observation of this handover indicated that there was no reason why he should not have done so. This typifies many of the handovers observed and



recorded and is indicative of the more general lack of evidence of any health education activity on this ward.

The recorded interactions therefore highlight key aspects of the nurses' approach to patients - that is, that it was nurse-led and orientated around aspects of physical care needs only. This approach meant that attempts to foster the patient's collaboration and participation in the care-giving process were lacking.

#### Absence of health promotion concepts and skills

Analysis of data from the multiple sources of data collection utilized revealed that in addition to the limited development of health education practice on Ward 1, activity at a health promotion level, embracing relevant concepts and skills, was also largely absent from nurses' practice. That is, nurses were not engaged in helping to create an environment conducive to the promotion of health through the formation of health enhancing policy and/or inter-sectoral health promotion work with other professional or lay groups. The researcher's observation and field notes indicated that the nurses did not collaborate for example, with personnel such as the stoma care sister or the diabetic health visitor - potentially useful health promotion resources as outlined at the beginning of this Chapter. The only exception to this was the ward sister's involvement in a multi-disciplinary working group convened by the Chief Executive of the DHA and which had been set up to establish a District policy on nutrition. She had been nominated for this and was not actually sure what her role in this would involve, although potentially it could represent a development of the ward sister's health promotion role in that it was an opportunity to engage in work with others on an issue pertaining to health at a policy level. No other examples of nurses' involvement in multi-sectoral or multi-agency working on health promotion issues were evidenced during the many hours spent on the ward. Other than the one example of the nutrition policy described above, there was no evidence to suggest that formal or informal mechanisms or structures existed for work of this nature either within the hospital or incorporating a wider community or District Health Authority focus.

Analysis of field notes about unrecorded observed events such as office and bedside handovers as well as more general observations about ward events and conversations confirmed the above findings - i.e. a lack of any health education and health promotion practice - and thus lend validity to the findings. They also enable some explanatory statements to be made about the findings from Ward 1 and these are presented below.

### Potential Influences on Practice

Firstly, it was apparent that the general approach to care was not consistent with the development of health education and health promotion by nurses on the ward. Both field notes, non-participant observation notes and recorded interactions indicated that the nurses were operating predominantly with what appeared to be a medical model philosophy of care with its focus on the patient as a collection of symptoms of physical illness, and a traditional distinction between professional and lay competence and knowledge. This is apparent from the data presented above and the researcher's field notes about other observations that nurses were orientated to completing tasks rather than achieving individualized, holistic care of which health education was a part. Clearly this militates against the incorporation of a health focus, as well as activities designed to prevent rather than cure disease and a collaborative approach to care which is characteristic of health education and health promotion.

Related to this was the way in which the ward was managed and the allocation or organization of nursing care as evidenced at the end of shift handovers. This also appeared to exert an inhibitory influence on health education and health promotion. The ward sisters had a clearly defined hierarchical management style such that individual staff members had little decision-making powers or autonomy in their work. They were allocated work by the ward sister or person in charge at the beginning of a shift and their allocated patients changed frequently, often on a daily basis, resulting in a lack of continuity of care and individual responsibility for patients. The ward sisters were also observed to carry out the drug and ward rounds and to make decisions about patient care which overrode the individual nurse caring for a particular patient thus appearing to result in a lack of autonomy for individual practitioners. A further finding which is perhaps also characteristic of nurses' lack of autonomy in the decision-making process is that little evidence was collected of their involvement in planning and / or implementing health promotion at a policy level. These factors are likely to have had a disempowering effect on the nurses and this is a point returned to below in relation to their influence on nurses' ability to develop their health education role in a way which encompasses patient empowerment.

In addition, the lack of continuity and responsibility for individual patients' care appeared to prevent individualized and holistic health education based on a therapeutic nurse:patient relationship. For example, nurses did not know what, if any, health education advice the patient had already received and/or may have been disinclined to begin an education process with a patient that she did not feel individually responsible for and/or may not be able to follow up on. This system of organizing nursing care appeared to reinforce the

predominant ideology of patients being seen as a series of physical care tasks and thus health education was excluded from the nurses' agendas.

Field notes also documented that a lack of knowledge and skill with regard to health education and health promotion may have contributed to its absence from practice. Several nurses mentioned this to the researcher in informal conversation and this is verified by some of the examples of information-giving recorded as outlined earlier. Biographical details provided by the questionnaire data also appear to support such an interpretation: the nurses on Ward 1 had trained with a traditional, as opposed to a Project 2000 curriculum and the data showed that they had received little post-registration education and / or input on health education and promotion principles and skills. The lack of knowledge about health education and health promotion with which nurses were operating is also reflected in the findings from the questionnaire data (see above). These indicated that the nurses held limited perceptions about the concepts and their role and that their ideas were largely confined to traditional concepts and activities. These limitations in the nurses' knowledge and understanding is likely to have prevented a more comprehensive development of their role and helps to explain the form of current practice, as presented above.

Finally, it appeared from the data collected on Ward 1 that the nurses lacked support from management and this, coupled with the busy and stressful nature of the ward environment, appeared to result in lowered morale. For example, the researcher recorded a conversation in the field notes between two nurses who had been threatened by a patient with a knife the previous evening. The nurses were keen to seek legal advice to pursue their case and had sought management support for this. In response, they had been told that they would have to pursue their case independently of any support from nurse management. Together with the hierarchical manner in which the ward was managed, nurses' lack of involvement in policy level decisions and their limited knowledge about health education and promotion concepts and skills, the net result appeared to be that nurses felt unsupported and disempowered. This may explain why they were not in a position to act as effective health educators, as the above data shows. As previous authors have suggested (e.g. Clarke 1991; Tones 1993) nurses themselves need to be empowered in order to be able to empower others. The corollary may also be true: if nurses are disempowered, they are more likely to disempower their patients by employing strategies (as evidenced above) that help them maintain power and control over them.

To summarize, analysis of data from a number of different sources revealed a similar picture of practice: apart from some minimal attempts at information-giving, health education and health promotion were absent from nurses' practice on this ward. Many

observed and recorded interactions were characterized by the antithesis of health education principles in that they were medically-oriented and nurse-led. There was no evidence of collaboration with patients or of attempts by nurses to clarify beliefs and values or foster patients' life-skills, self-esteem or feelings of empowerment as part of the process of education and advice-giving. Health education information, such as that pertaining to preventative services or structural influences on health was not being delivered on Ward 1. In addition, apart from one reported example, involvement in health promotion at a policy level or engagement in inter-sectoral work on health issues was not a feature of nurses' practice on Ward 1.

The ward appeared to be functioning with an underlying medical model philosophy of care and was consequently managed on traditional, hierarchical lines. These factors, together with nurses' apparent lack of knowledge and skills in health education and health promotion, seemed to contribute to their disempowerment and may have been instrumental in inhibiting the development of health education and health promotion at ward level. These findings are discussed further in the light of the findings from case study Wards 2 and 3 at the end of this Chapter and in Chapter Six.

## **Ward 2**

### **Background**

Ward 2 is situated in a large teaching hospital on the outskirts of a city with a predominantly Caucasian population. All trainee nurses have supernumerate status and follow an under-graduate curriculum modelled on that offered to Project 2000 students – i.e. it has a health-orientated focus – at the local Higher Education institution. Ward 2 is a twenty bedded mixed ward comprising patients with a wide variety of general medical conditions. These include: critically ill patients, for example patients who have suffered myocardial infarctions and cerebral vascular accidents; patients requiring rehabilitation; patients admitted for diagnostic purposes and those with acute social breakdown or multiple pathology.

During the time of data collection, few admissions were booked admissions - most were emergencies that came to the ward via the Accident and Emergency Department. The mean age of patients (based on analysis of one week's admissions recorded in the nursing records) was calculated to be 66.3 years and the average length of stay was 8.77 days.

At the time of data collection the ward had been practising primary nursing for three years. Team members were permanently allocated to a team and were allocated their own primary patients within the team structure. These patients were initially allocated to staff on a dependency basis, each patient being given a dependency score through a dependency system based on Orem's model of nursing. Staff working on Ward 2 comprised:

- 1 senior sister
- 3 senior staff nurses
- 13 staff nurses
- 4 part-time staff nurses
- 1 auxiliary nurse
- 1 ward receptionist (part-time)

At the time of data collection the ward was one E grade staff nurse below establishment. There were no students in the establishment figures - those that came to the ward from the college were supernumerary. Analysis of the biographical details provided by staff who returned their completed questionnaires (70% n=14) (see Table

9) revealed that the length of time these nurses had been on the ward varied from 1 month to 4 years and 6 months, with a mean of 14.3 months. These respondents had a high level of further or post-registration qualifications. Forty-three percent (n=6) currently held or were undertaking the Bachelor of Nursing degree, 14% (n=2) had diplomas, and 21% (n=3) held ENB approved courses. In addition, the ward sister was one of the most highly qualified of the sample of ward sisters who were interviewed, holding both a Diploma and Masters Degree in Nursing as well as a Certificate in Further Education.

**Table 9: Biographical characteristics of nurses returning questionnaires on Ward 2.**

|                                    |                                |
|------------------------------------|--------------------------------|
| <b>Q'sres distributed</b>          | n=20                           |
| <b>Response rate</b>               | n=14 (70% )                    |
| <b>Grade/position</b>              |                                |
| Student nurse                      | 0                              |
| Enrolled nurse                     | 0                              |
| Staff nurse                        | n=6 (D grade)<br>n=4 (E grade) |
| Senior staff nurse                 | n=4 (F grade)                  |
| <b>Length of time on ward:</b>     |                                |
| <b>Range</b>                       | 1m-4years 6m                   |
| <b>Mean</b>                        | 14.3m                          |
| <b>Qualifications:</b>             |                                |
| ENB course                         | n=2                            |
| ENB 998                            | n=1                            |
| C&G 730                            | n=2                            |
| Cert. Ed.                          | 0                              |
| Nursing Diploma                    | n=2                            |
| Nursing Degree                     | n=6                            |
| <b>Length since qualification:</b> |                                |
| <b>Range</b>                       | 2m-22years                     |
| <b>Mean</b>                        | 2 years 8m                     |

The annual staff budget for 1991-1992 was £272,669 which included all night duty, bank cover for sickness and some secretarial time.

A nursing handover consisting of the name, age and diagnosis of patients was held in the ward office at lunchtime and evenings followed by full handover at the bedside between primary and associate nurses caring for each individual patient. Morning handover from night to oncoming early shift staff was via a tape-recorder in the office, followed by walkaround introductions by on-coming staff to patients at the bedside. Care plans were kept in folders at the end of each patient's bed.

The ward philosophy was a written document (see Appendix 10 ) displayed on the ward. This was also explained and illustrated for patients in the form of ward photographs in an album.

There was some evidence of health education literature and some displays on the ward. At the ward entrance was a small table and stand displaying health education and health promotion leaflets. These covered a wide range of topics including incontinence, diabetes, cancer, cardiac related diseases and social security booklets. Adjacent to this was a notice board entitled "Promoting Your Health" which displayed healthy lifestyle type posters concerning alcohol, diet and exercise. Relaxation tapes were available on the ward and some staff were skilled in massage. Additionally, a number of personnel were available as resources. These included clinical nurse specialists in diabetes, stoma care, and incontinence.

### Data Collected

Data were collected on Ward 2 over a period of four weeks. A total of 20 questionnaires were given to trained staff on the ward and 14 (70%) were completed and returned (see Table 9). As students were supernumerary on the ward and were predominantly observing care at an early stage of their training, they were therefore not included in the questionnaire sample on this ward. The researcher interviewed six members of staff for their views on their health education and health promotion practice - these interviews were also tape-recorded and transcribed. As described in Chapter Three, the researcher decided to employ informal interviews to elicit nurses' views on this particular case study ward because, unlike the other case study wards, some development of nurses' health education and health promotion practice was found on Ward 2. It was felt that the data gathered in this way would offer insight into this

development and serve as an adjunct to both the questionnaire data and the researcher's field notes in highlighting the influential factors involved.

Tape recorded interactions (n=9) included discharge advice to a patient following a myocardial infarction, two bedside handovers, patient assessments and educating a patient about medication. The sampling of events on this ward differed from the other case study wards because of the way in which care was organized. Staff suggested that health education and health promotion were integrated into care such that it was impossible to identify specific times and incidents for observation and recording. Similarly some common nursing procedures did not exist as such - admission was not a focused one off event amenable to tape recording but was a continual assessment by a primary nurse over the first forty eight hours. Therefore the researcher explained the aims of the project and, when appropriate, allowed the data collection to be guided by the staff. The staff proved helpful at involving the researcher in their work when health education and health promotion activities were taking place.

The observation periods covered (n=9) ranged from early morning to late evening and were on average for a period of two hours duration. In addition four specific incidents identified by nurses immediately prior to them carrying them out were observed, for example a patient teaching session.

Field notes were also made on a daily basis about many other events and conversations witnessed as well as features of the nursing practice on the ward. These allowed perceived influences on nurses' health education and health promotion practice to be described.

Findings from Ward 2, together with illuminative examples, are described below.

### Nurses' Perceptions of Their Health Education and Health Promotion Role

In response to the questionnaire item asking nurses to specify their role in health education and health promotion, a variety of comments were made, all of which were focused at the level of the nurse- patient interaction. Ten (71%) of the 14 nurses specifically identified what they considered their role to be, and of these, 5 (36%) related this to giving information, advice or education. For example, two responses were as follows:



*"To inform patients of all medication and procedures etc; they are undergoing - why mainly and what for and to answer any questions they may have."*

*"I see my role as adviser and teacher in relation to health education."*

Four of the other nurses on Ward 2 identified the nurse's role as that of discussion or advice about aspects of patients' lifestyles. One wrote:

*"Educating both patient and family to prevent recurrence of acute illness re. diet/ lifestyle/ illness risk factors occurs while in hospital in preparation for discharge."*

And another response was:

*"I feel I have a responsibility to help my patients help themselves. Health education plays a vital role in this. When I assess a patient, if I see a part of his life that s/he can make healthier, I should point this gently and tactfully out."*

Whilst these nurses recognized a role for themselves as advisers or givers of information, a recognition of the skills involved in this process was not apparent from their responses. That is, the concepts inherent in the self empowerment model or new paradigm approach to health education were lacking from the responses. For example, none of the nurses mentioned empowerment, the need for individualized advice or the need to address structural barriers to health choices within the context of an interaction. In addition, none of the respondents outlined a role for themselves beyond the nurse-patient interaction - for example, in relation to creating environments or policies conducive to health. Nonetheless, when specifically asked about this in the questionnaire, 13 of the 14 nurses (93%) considered that they had a role in influencing hospital health promoting policy. Asked to identify ways in which they might do this, 4 (29%) of the comments related to the need for nurses to liaise and collaborate with others. For example, two felt that:

*"We do meet with catering staff on occasions. I'd like to clarify policies on smoking, it involves working between wards as dayrooms are shared."*

*"We have liaised with the dieticians and Medi-clean to provide a better menu service. However, I feel we are not consulted enough."*

Two of the other nurses felt that the way to influence policy was through the nurse management structure in the hospital and another two comments pertained to the importance of patients' ability to make their opinions felt. Other comments (n=3) revolved around the need for nurses to be assertive, to petition relevant people and to speak to their unions / professional body.

Thus, whilst nurses did not initially identify a role for themselves in influencing health promotion policy, when specifically asked about this there was near unanimous agreement that this was part of their role. This suggests that they do not associate the concept of health promotion with that of policy change. Nurses' responses also indicated that they could identify insightful ways in which they might influence policies in the hospital in the interests of health. Despite this however, there was a lack of evidence from Ward 2 to suggest that they were actually engaged in these types of activities. Nurses' practice on Ward 2 is described more fully below.

#### Nurses' Health Education and Health Promotion Practice

Analysis of data collected from the various methods described above enabled an overall picture of practice to emerge. This revealed that nurses on Ward 2 were integrating certain elements of health education into their care. For example, the giving of information to patients was frequently observed to be given in a manner congruent with health education principles by some of the nurses. Nurses also appeared to be engaged in educating patients about various aspects of their illness and some attempts at encouraging patients to participate in their care were noted. However, there was less evidence of relatives participating in care or of nurses offering advice related to health as opposed to the patient's presenting illness. In addition, activity was focused at a one:one nurse:patient level, as opposed to nurses' involvement in health promotion policy formation and / or inter-sectoral working with other professional or lay groups. More specific findings, together with supporting evidence, are outlined below.

#### Collaborative information-giving

Analysis of observation notes indicated that the majority of staff routinely gave information to patients. At its most basic level this revolved around informing patients of what they (the nurses) were about to do, for example turn the patient or take their blood pressure, whilst other examples included more comprehensive information about an impending procedure or investigation or information about a patient's treatment or plan of care. Often this would occur at the beginning of a shift or following a doctors'

round nurses would check the patient had understood what was said and if necessary explain. For example observation notes record:

*"15.59:N15 asks P17 if he understood what all that was about as Dr and 4 colleagues leave. P17 says not all of it. N15 sits on the bed and explains to the patient about the changes in his eye and that this may mean he has high cholesterol....that the doctors have ruled out he is having little heart attacks that they are not sure what is causing the breathlessness but that they are happy there is no major problem...and that he may be able to go home by Saturday or Sunday."*

Patient education often appeared to take the form of a more pre-planned session, but was also integrated into care and undertaken in response to patient questions or cues. For example a nurse was observed going through the medications of a newly admitted patient, showing him his drug chart and explaining what each one was for, and which ones were omitted and why. Also, after taking a patient's temperature, pulse and blood pressure a nurse was observed explaining about heart failure and left ventricular failure in response to the patient's question about his pulse. This involved the nurse drawing a diagram and explaining the blood flow through the heart. On another occasion a pre-planned session was observed and tape-recorded in which a nurse was educating the patient about her medications prior to discharge:

N11(2): *"So when would you take this, do you think?"*

P: *"Well if I ever get that pain there. But some days I only get it once a day or not at all. I don't take it if I've got no pain."*

N11(2): *"That's right. And do you have a rest at the same time?"*

P: *"Yes, I always sit down for about 10 minutes, quarter of an hour after I usually get that pain if I've done a bit of hoovering, you know"*

N11(2): *"That's right. And you were saying yesterday that you know how much you can do and when you've got to stop."*

(Tape recorded handover)

This excerpt reveals a collaborative and individualized approach to the education process - the nurse assesses the patient's knowledge and usual management of her illness and reinforces this without imparting unnecessary advice of her own. This particular nurse was a recent graduate and it is possible that the appropriate knowledge and skill required for this type of approach are linked to the educational level achieved. Indeed, a number of examples similar to the above were observed and / or recorded revealing that staff on Ward 2 appeared to have the skills necessary to undertake health education in this way. A further extract from a tape recorded bedside handover illustrates other nurses' collaborative approach:

N15 (2): *I'm X and I'm going to be looking after you this afternoon.*

P: *OK*

N15 (2): *Alright, I know that you've seen me but I haven't been looking after you for too long.*

P: *No, no, I've seen you around.*

N5 (2): (to patient) *Do you want to tell X what has been happening this morning?*

P: *Well, yes. I mean I had a couple of X- rays and a couple of scans.*

N15 (2): *Oh, good.*

P: *Um....I was going to have one, but when I told the young doctor about the swelling in my ankles and when I saw the consultant they had the X-rays , so he said, "Are you alright?" and I said "Yes" and he said, "You don't sound it" and I said "Look at this" you know*

N15 (2): *Is that a new problem then, or just happened?*

P: *I don't have it very often, but I told the nurse about it*

N15 (2): *Don't worry, it's not an unusual problem.*

(Tape recorded handover)

This example clearly shows the nurses' commitment to involving the patient in the interaction in order to obtain her perspective about her health needs.

Bearing in mind the comparatively high level of educational attainment of the nurses on this ward, a link is again suggested between this and the skills necessary to put into practice key health education concepts as they are currently understood. This point is returned to below.

#### Selective patient participation

Both observation notes and transcripts of recorded interactions indicated that attempts were being made to encourage patients to participate in some aspects of their care. For example, documentation was kept in folders at the end of patients' beds and had notices attached which read: "Please do not read these notes without permission from the patient." Some nurses were observed to ask patients before looking in these folders and patients were encouraged to be involved in the writing and reading of their care plans. An example from the observation notes illustrates this. Completing a care plan, a nurse says:

N12(2):       *"There you are read that and see what you think".*

                  (Puts the folder on the patient's bed).

P:               *"Am I allowed to read it?"*

N12(2):       *"Yes of course you are, its for you to read."*

P:               *"Years ago you would have got your hands chopped off if you'd have touched that."*

This exemplifies the collaborative approach to care which characterized some of the observed and recorded interactions on Ward 2. The patient's reaction to the nurse's cue to become actively involved is also interesting, indicating that his previous experience of the health care system has resulted in expectations about the patient role which do not include participation in care.

In addition, bedside handover was utilized by staff as an opportunity for encouraging patients to participate in their care. Although some nurses appeared to have developed this approach more than others, patients were frequently encouraged to participate, for example by being asked to describe what they had done or how they had been feeling during the shift:

- N1(2): *"Right, X is looking after you this afternoon."*
- P: *"Yes, alright."*
- N1(2): *" O.K., um...I'm going off shortly. Do you just want to tell her how you've been?"*
- P: *"Well, I've been quite well, I had a bath yesterday, had a wash today. And generally, getting better. I go to the toilet alright and very well."*
- N5(2): *"Yeah?"*
- N2(2): *"Do you think that you are generally improving X?"*
- P: *"I definitely am, very much so. I'm going home tomorrow*
- N2(2): *"Great."*

Bedside handover was generally participatory with communication mostly being nurse-patient rather than nurse-nurse centred. Staff tended to include patients and not talk over them, and frequently sat on the bed or stood or squatted beside the patient to facilitate this. They did not remain at the end of the bed, and the focus was the patient rather than the patient's charts.

#### Lack of comprehensive development of health education and promotion

Despite the development of certain aspects of health education by nurses on Ward 2, other features of this role were largely lacking from the data collected on nurses' practice. For example, analysis of the various forms of data collection revealed no examples of relatives participating in the care of patients on Ward 2 and some opportunities for patients to participate in their care were not being utilized by the nurses. Furthermore, examples of nurses' involvement in health education were limited to a focus on the patient's illness, as opposed to advice about a healthier lifestyle *per se* or that with a health -orientated focus. Some minimal attempts to discuss smoking and dietary habits of patients were recorded (see Appendix 11). However, incidences of nurses engaging in dialogues about patients' lifestyles were limited in scope and skill and less frequent than either straightforward information-giving or patient education.

Finally, no evidence was collected of nurses working with other lay or professional groups on health issues in the spirit of current health promotion philosophy, and in general engagement in health promotion activity at a policy level appeared to be lacking on Ward 2. There appeared to be no facility for nurses to become involved in inter-sectoral or the policy level types of work outlined by the nurses themselves in their questionnaire responses. It seemed that the hospital as an organizational system militated against this. This point is returned to in the discussion of results in Chapter Six.

Analysis of the researcher's field notes about the many events and conversations that were observed on Ward 2, as well as a number of tape-recorded informal interviews with staff allowed a number of influences to be identified that were conducive to the development of health education. Constraints on further development of this role were also noted. These are described below.

#### Potential Influences on Practice

The ward philosophy appeared to be a key influential factor in the development of health education seen on the ward. Central elements of the philosophy underpinning care on Ward 2 (see Appendix 10) appeared to be a respect for patients and their rights, as well as a philosophy of nursing which valued individualized, holistic care, partnership, patient control and continuity of the nurse:patient relationship. Clearly, these are also important elements of health education. These ideas were not only enshrined in the written ward philosophy, but also seemed to be enacted by the nurses in their practice. The written philosophy also identifies health education as an important goal, as the following extract from it shows:

*“Knowledge enables people to look after themselves and help prevent recurrence or exacerbation of illness. It is therefore an important nursing responsibility to educate patients and their families.”*

The philosophy was also made accessible to patients by having an album of ward photographs illustrating aspects of the philosophy for patients to look at and read through. This not only indicates that the philosophy was actively being shared in practice, it forms a further example of the collaborative approach taken by the nurses with the patients on Ward 2. The important influence of the philosophy of care was identified by the nurses themselves: 4 (29%) of those who returned questionnaires spontaneously identified this shared philosophy of care as a factor facilitating their

health education and health promotion practice. Several of the nurses also commented on the importance of the ward philosophy when asked in an informal interview to identify the reasons why they felt that health education had developed on the ward. The following extracts are taken from informal interviews with three different members of the nursing staff:

*"I mean, people have a right to sort of know what's going on with their health, and to make their decisions for themselves. And I think it's just a thing that's evolved on the ward . . . . it's very much sort of part of the ward philosophy . . . that everyone believes in."*

(Taped interview)

*"It's part of the general philosophy of the ward, I think, that education is important, and that a patient should have that education so that they can make decisions for themselves. They should have the power to do that."*

(Taped interview)

*"It's going back to the philosophy again – there's an understanding – and support there for – that relationship to be built between the primary nurse, or even the associate nurse, and the patient. So in fact we do understand yes, we allow space for that to happen."*

(Taped interview)

These comments also highlight the fact that the philosophy was one which was shared and which all of the staff were committed to. Several others commented that they felt the philosophy had originally emanated from the ward sister. A primary nurse on the ward felt it was often up to the ward leader to be a role model and to guide the ward staff, and that the philosophy and approach to care on the ward emanates from the manager in the first instance. One other nurse commented on the influence of nurse management in a tape-recorded interview:

*"I think that the nursing structure itself, the nursing management structure, was supportive of the type of nursing we were doing here."*

(Taped interview)



The researcher felt that the ward sister appeared to have recruited nurses with similar ideas or philosophies about nursing care such that basic principles were internalized and developed by the staff and a common understanding existed. A number of staff identified recruitment of staff as a key facilitating factor which helped health education develop on the ward. One staff member said:

*“Over the last three years we recruited staff who are obviously sympathetic to the type of nursing we were going to do on here.”*

(Taped interview)

A second influence perceived by both the nurses and the researcher to be beneficial to the development of health education concerned the democratic manner in which the ward was run. This was closely associated with the well-established system of primary nursing in operation on the ward and manifested itself in devolved decision-making and the absence of a nursing hierarchy on the ward. This was perceived as favourable by several of the nurses. One reflected:

*“The fact that the ward is so non-hierarchical is also a very positive influence and helps. Everyone is responsible for their own work, organizing and planning it. If you say to the ward sister, ‘Can I have a half day?’, she’ll say, ‘Well, can you? I don’t know’.”*

(Taped interview)

A second felt that:

*“When X (ward sister) started here, and she came with the idea of introducing primary nursing.....um, as a way of giving us more control...in our practice and a way of giving us more power, and I think it’s just evolved in that we want to now give our patients more power as well.”*

(Taped interview)

This democratic management style was also spontaneously identified as a facilitating factor by 2 (14%) of those who responded to the questionnaires. The researcher’s field notes also document examples of the lack of hierarchy. For instance, the ward sister was not distinguished from the other nurses on the rota or by virtue of her uniform and

was a permanently established member of a ward team who acted as a primary nurse alongside the other nurses. Individual nurses planned and implemented care for their patients without directives from the ward sister. Additionally, any enquiries about individual patients from relatives or other health care professionals were re-directed by the ward sister or co-ordinating nurse to the primary nurse caring for that particular patient. That is, the ward sister or co-ordinating nurse did not erode the autonomy of other primary nurses by assuming responsibility for communicating about their patients. More generally, the researcher felt that the ward sister helped to foster a ward climate in which individual nurses felt valued and supported members of a team. This also appeared to be facilitated by the system of primary nursing in operation.

The democratic, as opposed to hierarchical, way in which the ward was managed involved devolved decision-making and appeared to encourage responsibility and accountability in individual nurses. This may have had the effect of contributing to their sense of empowerment and this may have increased their desire and ability to empower their patients as the latter extract from an informal interview indicates. As well as offering opportunities for empowering nurses, the established system of primary nursing in operation on Ward 2 was also considered to have other facilitative influences on nurses' ability to put health education into practice by both the researcher and the nurses themselves.

Nurses on the ward had primary responsibility for a small group of patients within a primary nursing framework, and some staff on the ward identified this as a key facilitator of their health education and health promotion practice. From the questionnaire data 36% (n=5) spontaneously identified the organization of care on the ward as helpful. Advantages of primary nursing which were related to health education identified by staff included continuity, better relationships with patients, responsibility, autonomy and a tool to help increase nurses' knowledge. One nurse said:

*"I think the thing which is utmost, the reason why it (health education and health promotion) happens so much, is that you can continue your care day by day."*

(Taped interview)

Continuity of care was perceived to enable effective assessment, planning and evaluation of any health education with the patient. Another nurse commented:

*"We all saw the benefits of primary nursing. And I suppose that's really the partnership, then, of the nurse and the patient – enables the sort of therapeutic relationship, and not only that, but it also helps with assessing their health needs and the education of that patient "*

(Taped interview)

One nurse also considered that this responsibility encouraged nurses to develop a sound knowledge base which was useful to the development of nurses' health education practice. She said:

*"It's also to do with the responsibility of actually being a primary nurse, because you're always – there's a need to try and keep yourself abreast with present knowledge."*

(Taped Interview)

A further influential factor identified concerned the educational or knowledge level of the staff. The influence of the relatively high level of educational attainment of many of the nurses was referred to earlier. It also appeared from the data collected that the further acquisition and sharing of knowledge at ward level was valued highly by the nurses and the ward climate supported them in this. The researcher noted numerous ways in which this learning was facilitated. For example, according to the ward sister and other more senior members of staff, the recruitment of staff was based partly upon the skills and knowledge they had to offer and, as a result, there were several ward staff who acted as resources on various subjects, for example, cardiology, diabetes and palliative/terminal care. Staff shared their own individual expertise and resources with each other and often had group learning sessions on the ward. In addition, a "journal club", which involved the nurses presenting and discussing research-based nursing articles, was held weekly. The researcher also noted that there seemed to be a sense of social cohesion between all of the staff on Ward 2, with nurses spending time together socially outside of work hours. The nurses on Ward 2 gave feedback to each other following study days and many were also student mentors which appeared to give staff an incentive to increase their own knowledge. Mentors were also encouraged by the ward sister to keep reflective diaries.

The facilitative influence of knowledge and education was also identified by members of the nursing staff. Three (21%) of questionnaire respondents spontaneously

identified the knowledge of staff on the ward as a facilitator of health education and health promotion. Money for study days and courses was provided from ward funds under the direction of the ward sister who saw this as a priority. Five (36%) of questionnaire respondents identified encouragement by the ward sister to acquire knowledge as a facilitator of their health education and health promotion practice. The ward was fortunate to receive fairly generous patient donations in comparison to other wards visited by the researcher and much of this was reported to be used in the further education of staff.

The overall impression from the data collected on Ward 2 was that the nurses had achieved comparatively high levels of educational attainment and that continued learning and knowledge development was encouraged and facilitated by a number of supportive features of the ward, such as the journal club and the availability of funds for study leave. This impression was substantiated by the written ward philosophy, which stated that:

*"It is every nurse's responsibility to continue his/her education and to share this knowledge with others. Learning opportunities are provided on the ward and staff are encouraged to attend study days where possible."*

The value placed on the nurses' education and the educational qualifications which they had achieved may have been linked to their ability to integrate health education into practice. However, it is also likely that a lack of specific knowledge about health education concepts and principles - demonstrated by the questionnaire responses presented at the beginning of this Chapter - may have been a factor constraining further development of this role. This point is returned to in the discussion of findings in Chapter Six.

Finally, the ward sister was found to have a considerable degree of autonomy in the day-to-day management of the ward. As one nurse put it during an informal interview with the researcher:

*"I mean, X's role – she seems to have such – well, clout, for want of a better word, in that she's got management responsibilities, she's got responsibilities of budget, she can do what she wants in terms of planning the ward . . . . and that was fundamentally important . . . . that she had – she has that autonomy – to run the ward."*

(Taped interview)

The researcher noted that the ward sister had no direct line manager to whom she was answerable, was responsible for her own ward budget and staffing and was able to implement changes at ward level at her own and the staff's discretion. (The researcher subsequently learned that this was a deliberate, hospital wide senior management policy to encourage autonomy - see Chapter Six). The apparent autonomy enjoyed by the ward sister may have contributed to her own sense of empowerment and this may also have been heightened by her educational achievements, which, as previously mentioned, were amongst the highest of the ward sister sample interviewed. This in turn may also have been associated with the finding that her management style was non-hierarchical and democratic, fostering responsibility and autonomy in staff.

To summarize, certain elements of health education did appear to have been developed on Ward 2. These included individualized information-giving to patients, some patient education and attempts to encourage patients to participate in care during for example, nursing bedside handover. However, the full potential for lay participation did not appear to have been realised, for example, no evidence was collected of relatives being involved in care. In addition, advice about health - as opposed to illness - related issues could have been further developed, as could nurses' involvement in collaborating with others on health promotion issues or engaging in activity at a policy level.

A number of facilitative influences which may explain the integration of health education into nurses' practice were identified from the data collected. These were the philosophy of care in operation, the organization of care via a system of primary nursing, the democratic management of the ward, the educational attainments of the staff and the ward sister herself. A number of these influences may have exerted their effect by enhancing the nurses' feelings of empowerment and this may explain their apparent desire and ability to adopt a more empowering approach with their patients. Possible inhibitory influences preventing the full development of a more comprehensive range of health education and promotion activities centred around the nature of the hospital organization itself. That is, it's illness-orientated focus and lack of opportunity for engaging in inter-sectoral or health promotion policy work with others either within or outside of the hospital setting. In addition, it is likely that nurses' limited interpretations of the meaning of the concepts prevented them from engaging in certain types of activity because they were not consciously recognized as health education or promotion or equipped with the necessary skills with which to enact them. These issues are discussed further in the light of the findings from the other case study wards at the end of this Chapter and in Chapter Six.

## **Ward 3**

### **Background**

Ward 3 is situated in a small satellite obstetrics and gynaecological hospital, forming part of a group of hospitals within a large industrial city. Nursing students follow a Project 2000 curriculum at the College of Nursing which is attached to one of the larger hospitals on the other side of the city. The ward is a 29-bedded gynaecological surgery ward with both elective and emergency admissions. Patients are commonly admitted for terminations of pregnancy, with threatened miscarriage, for investigations of infertility or for major surgery such as hysterectomy or bladder repair. Analysis of nursing records showed that patients are predominantly Caucasian and from the immediate locality, with an average in-patient stay of 4 days at the time of data collection. Analysis of the details of a random week of admissions revealed that the mean age of patients during that week was 32 years. At the time of data collection the staffing profile of the ward was as follows:

- 1 ward sister
- 1 senior staff nurse
- 5 staff nurses
- 1 part-time staff nurse
- 2 enrolled nurses
- 2 auxiliary nurses.
- 1 part-time ward receptionist.

There was no ongoing allocation of student nurses to Ward 3. The ward was up to its staff establishment level and the ward budget annually for staff was £125,454.

Table 10 shows an analysis of the biographical details provided by staff who returned their questionnaires (78% n=7). This shows that the length of time that these nurses had been employed on the ward varied from 10 months to 5 years, with a mean of 30.8 months. These respondents had limited further and/or post-registration education: none had obtained a degree or diploma, only one had completed an ENB approved course and another had obtained a Certificate in Education. Table 10 also shows that the length of time that respondents had been qualified ranged from 11 months to 13 years and 3 months, with a mean length since qualification of 5 years and 4 months.

**Table 10: Biographical characteristics of nurses returning questionnaires on Ward 3.**

|                                    |                                |
|------------------------------------|--------------------------------|
| <b>Q'res distributed</b>           | n=9                            |
| <b>Response rate</b>               | n=7 (78% )                     |
| <b>Grade/position</b>              |                                |
| Student nurse                      | 0                              |
| Enrolled nurse                     | n=1                            |
| Staff nurse                        | n=3 (D grade)<br>n=3 (E grade) |
| Senior staff nurse                 | 0                              |
| <b>Length of time on ward:</b>     |                                |
| <b>Range</b>                       | 10 m- 5 years                  |
| <b>Mean</b>                        | 30.8 m                         |
| <b>Qualifications:</b>             |                                |
| ENB course                         | n=1                            |
| ENB 998                            | 0                              |
| C&G 730                            | 0                              |
| Cert. Ed.                          | n=1                            |
| Nursing Diploma                    | 0                              |
| Nursing Degree                     | 0                              |
| <b>Length since qualification:</b> |                                |
| <b>Range</b>                       | 11 m- 13years 3 m              |
| <b>Mean</b>                        | 5 years 4 m                    |

Nursing care was reported to be organized and allocated on Ward 3 via a system of team nursing which had recently been introduced. Staff were divided into red and blue teams, with the most senior staff designated as team leaders. The ward sister, however, was not a member of either team and when on duty was 'in charge' for that shift; in her absence the senior staff nurse took on this responsibility which involved carrying out drug and ward rounds as well as decisions about the allocation of care to the nurses. Although every effort was made to allocate patients and staff according to their teams to ensure continuity of care, in practice the small staff numbers made this difficult and resulted in nurses swapping teams temporarily according to available team

members on that shift. The net result was that a mixture of team nursing and daily allocation to a geographically defined group of patients was being practised. Nursing handover consisted of a brief overview in the office of all patients on the ward from the person in charge, followed by a more detailed bedside handover between individual team members. The ward sister was present at the bedside handover of each individual patient, which meant that red and blue team handovers took place consecutively rather than simultaneously to cater for this. Patients' care plans were kept at the end of their beds, whilst the admission sheet with details of the patient's medical history, etc, was located in the nurses' office on the ward.

Data were also collected on the health education materials available to nurses and patients on the ward, and a wide range appeared to exist. Written information sheets detailing discharge and/or preventative advice about various gynaecological conditions were available for nurses to give patients (for example see Appendix 12). A number of posters on such topics as exercise, stress and factors affecting the cardiovascular system were displayed on both the ward corridor walls and in the dayroom. In addition, a major feature of one ward corridor wall was a large, centrally-placed board entitled 'Patient Information Board'. This was covered with around 30 to 40 different leaflets and notices with a gynaecological focus, ranging from such topics as family planning, HIV and AIDS, to pre-menstrual tension, menopause and bladder problems. Various local support groups were also advertised, such as a miscarriage support group and the local contact and support group run by the National Association for the Childless. This notice board also contained a message advising patients that if they required further copies of any leaflets, or any further information, they should not hesitate to ask at the nursing office, or ask any nurse.

#### Data Collected

Data were collected by the researcher over a four-week period on the ward. Nine questionnaires were distributed to the qualified registered and enrolled nurses on the ward, and of these, seven (78%) were returned. A total of 11 nurse-patient interactions were tape-recorded, comprising three patient admissions, one nursing office handover and three bedside handovers, one episode of pre-operative advice and one individual and two group discharge advice interactions. Eight two-hour observation periods took place, spanning the nurses' normal day from the arrival of the early shift to mid-way through the evening. Many other unrecorded events were witnessed, for example, office and bedside handovers, and descriptive and analytical field notes were made on a daily basis about these and the perceived influences on nurses' health education and



health promotion practice. The findings from data collection and analysis are described below.

### Nurses' Perceptions of Their Health Education and Health Promotion Role

Nurses' perceptions of their health education and promotion role ascertained from the questionnaire data revolved largely around individual education and information about various aspects of the gynaecological problems patients presented with. Three nurses (43%) commented on their role in providing education about the presenting gynaecological problem. One commented that she had a:

*“specific role in education regarding gynae. problems / infertility etc;”*

Another three (43%) stated that they had a role in providing education for rehabilitation and discharge. For example, one wrote:

*“to give appropriate advice before discharge, i.e. changing lifestyle somewhat after major operation.”*

Furthermore, two (29%) of the nurses felt that their role involved education and preparation for the surgical operation itself. Three (43%) of the respondents also mentioned discussion about wider health care issues such as “smoking / lifestyle / HIV etc;” and asking about “last cervical smears as well as breast self-examination.” Finally, one nurse felt that part of her role was:

*“To be aware of the patients' biological, psychological and social well-being.”*

Whilst the latter comment is suggestive of a more holistic perspective, the remainder of these nurses' comments did not suggest that they were cognisant of other concepts which characterize effective health education. In fact, their responses could be construed as representative of a more traditional and limited perspective with its emphasis on teaching and information-giving. Analysis of other data sources from Ward 3 confirmed that this was in fact how the role was being enacted in practice (see below). In addition, none of the nurses made reference to their role in health promotion, as opposed to health education, activities.

However, a different picture emerged when asked later in the questionnaire about nurses' role in influencing the hospital policies that affect health. All seven of the

nurses agreed that nurses had a role to play in this. But when asked to specify how this might be achieved, three of the nurses' comments indicated a misunderstanding of what this meant. For instance, one said that it was about, "educating the patient on a better dietary intake" and another that, "nurses do try to introduce the patients to healthy diets." These remarks are indicative of a limited conceptualization of the issue. Others however, made some relevant suggestions. Two (29%) felt that nurses could best have an influence on hospital policies via their nurse line management, whilst another felt that personally approaching the person responsible was the best approach. Another nurse referred to the need to be the patient's advocate and a final comment concerned a local initiative - "personalizing the service" groups - as a mechanism by which nurses could best enact this role. However, no evidence was collected of nurses' involvement in such activities on Ward 3.

Overall, these responses suggest a somewhat limited understanding of the concepts of health education and health promotion and nurses' role in these activities. Analysis of the data on the reality of nurses' practice on this ward allowed similar conclusions to be drawn. These are described below.

#### Nurses' Health Education and Health Promotion Practice

Analysis revealed that common findings about nurses' health education and health promotion practice underpinned all of the various forms of data collection utilized. Overall, the data revealed a limited development of health education practice by the nurses, and an underlying medical model approach to these and other activities. A more skilled and participatory approach, reflecting more recent concepts and principles of health education, was lacking. Activity at a health promotion level was also lacking. Preparatory information-giving was the main feature of nurses' practice. Isolated attempts by some nurses to encourage patients to participate in their care were noted. However, these were usually associated with set times or events, rather than fully integrated according to patient need, and tape-recorded interactions indicated that the approach taken and skills utilized in these activities was variable. Analysis of the researcher's field notes, as well as a number of informal conversations with several of the nurses, allow some explanatory factors for these findings to be proposed. More specific details and illustrative examples are presented below.

#### Task orientated agendas and prescriptive information-giving

Analysis of non-participant observation notes revealed that nurses were predominantly and consistently engaged in certain types of activities: on the whole, nurses were

engaged in non-health education type activities and interactions. Much of what they were observed to do revolved around the completion of particular tasks, such as recording patients' observations or washing and positioning patients in or out of bed. Patient interaction also seemed to follow this task-orientated agenda, such that interactions were often driven by the nurse's need to gather information from a patient in order to complete the task. For example, patients were often asked at the end of a shift how much they had had to drink in order that the nurse could complete the fluid balance chart. The researcher's impression that nurses' work was orientated around the completion of physical tasks is reflected in this entry in the field notes:

*"There seemed to be a sense of working to complete the tasks, doing what had to be "done" as opposed to giving holistic care."*

Despite this, non-participant observation did reveal that some information was being offered to patients. This finding was also confirmed through analysis of recorded interactions (see below). Examples of information-giving documented in the observation notes included telling patients that they would need suppositories and a shave later that evening prior to surgery, or why their vaginal loss was a certain colour and what to expect over the next few days. In this sense, it could be argued that the nurses appeared to be cognisant of the patients' psychological needs and were imparting information that would enable them to prepare and plan for impending events, thereby perhaps enhancing their feelings of self-control. However the way in which the information-giving process was carried out was not conducive to this, in that it was essentially nurse-led and involved brief, one-way communication from nurse to patient.

Analysis of non-participant observation notes also suggested that some potential opportunities for health education were being missed by nurses – for example, they did not collaborate with patients when evaluating and documenting care on the care plan, but stood at the foot of the bed and completed this without consultation with the patients. Writing or updating a patient's care plan would seem to represent an opportunity for engaging in collaborative health education, for example through the nurse eliciting the patient's feelings about her current condition and needs for advice and information in order to plan to meet these individual needs. The fact that care plans were updated without consultation with the patients is an example of the lack of existence of the two-way nature of the communication process underpinning health education on Ward 3 - a finding consolidated by both questionnaire data and recorded interaction transcripts.

Some conversations that took place were also indicative that not all patients' needs for information were being met. For example, during one non-participant observation period, two patients due for surgery the following day engaged the researcher in conversation about what they might expect to happen. One asked what size the uterus was, because she had been told that she would only have a small cut and the other asked how long she would be under anaesthetic and went on to reveal that her husband had died after a heart by-pass operation, having never regained consciousness from the anaesthetic. Although the conclusions that can be drawn from the observational data alone are limited, this episode suggests that some patients' needs for information were not being met, indicating that the nurses were not fulfilling their health education potential in this respect. This is reflected in an entry in the field notes:

*"I think the unmet information needs was the main conclusion of today's observation."*

In addition, the researcher's observation notes did not reveal any examples of nurses' engagement in patient education about aspects of their illness or a dialogue about patients' lifestyles with a preventative or positive health focus. Neither were relatives observed to participate in aspects of the patients' care on Ward 3. The emergence of information-giving as the dominant form of health education which followed a nurse-led, one-way communication process and a more general absence of development of other aspects of a health education and promotion role is also confirmed by analysis of the taped recorded interaction data, below.

Data from a number of tape-recorded nurse-patient interactions indicated that opportunities were being taken to offer patients information about what to expect during their admission, thus presumably having a preparatory function. It appeared that the admission procedure was regarded by nurses as an opportunity to prepare patients for surgery or, more generally, about what to expect during their stay on the ward, as the following excerpts indicate:

P:           *"No, I've no problems, I'm supposed to have a urine infection but it's given me no problems, it's not bothering me at all."*

N3 (3):     *"Oh, any symptoms from it?"*

P:           *"No."*

N3 (3): *"Right, well we'll carry on with those antibiotics and get the full course. Make sure that we can get rid of it alright. Right, I'll explain what's going to happen then. The anaesthetist has seen you, hasn't he? All we need to do is keep taking your temperature every four hours, just to make sure that it's fine, but I think it would have been up when you came in if it was going to be over. We just need to keep an eye on that. You'll need shaving this evening which you can do yourself. Have you done it already? - forward planning. That'll just need checking then and you'll need two suppositories after evening visiting. We'll not do it before 'cause obviously you can't go to the loo."*

And later in the same admission a similar example of preparatory information-giving occurs:

N3 (3): *"Is X going to 'phone up to see how you are?"*

P *"There's only him 'phoning in."*

N3 (3): *"Brilliant. The operation will take about an hour and then you'll be going to theatre for another hour, so you'll be off the ward for a good couple of hours. So tell them to leave it for a good few hours before they phone up, probably very early afternoon, say one o'clock-ish to see how you are. When you come back you will have a drip up, just to keep you hydrated until you're drinking on Thursday morning. Um...that's basically all you'll have. We'll come to you every hour when you come back to the ward, make sure you're comfortable and not in any pain, even if it's a bit of discomfort, tell us and we can give you an injection to take it away, and also put in your anti-sickness injections in with that, 'cause of the anaesthetic. It depends how you react to anaesthetics. How have you been with the other ones?"*

P: *Alright.*

N3 (3): *You've been alright. The chances are that you'll be fine then.*

P: *I just sleep like a log.*

N3 (3): *Great, but we put in anti-sickness just in case. Um...and that's basically it. You'll be quite drowsy for most of tomorrow. Um...give you a nice towel bath on Thursday morning, you've had bed baths I presume, haven't you?*

P: *Yes, I have."*

The above excerpts indicate that although the nurse appeared aware of the patient's psychological need for information, there was no attempt to elicit the patient's agenda in order to offer individualized advice. For example, it is evident from the above that the patient had had previous experience of anaesthetics, but this knowledge is not acknowledged or assessed by the nurses prior to her explanation to the patient. Rather, the process is top-down and nurse-led, with the patient's role confined to confirmation of the nurse's question. Thus, although information-giving was evident in the recorded interactions, the process often did not exhibit the characteristics of a new paradigm approach to health education in that it was not collaborative or participatory and is unlikely to have resulted in patient empowerment.

#### Information for discharge home

Another feature of nurses' practice on Ward 3 was their involvement in informing patients about discharge, either individually or in an informal group setting. Nurses appeared to be offering advice on a range of subjects to prepare the patient for discharge and management of the rehabilitation period. Examples included information about possible symptoms and return to normal activities such as driving, work and sexual activity. The following data, from a group session on discharge advice given by a nurse exemplifies this:

N4 (3): *"Right, have you all read through these sheets then explaining what your ... It's basically advice on discharge, you don't have to follow this to the letter if you don't want to, but it's really, you know, just some guidelines as to what to do and what not to do when you go home, and basically I'm just here now to clarify any points that you don't understand or answer any further questions that you've got, so have you all read through it?*

Ps: *Yes.*

N4 (3): *It's all quite clear, is there anything that you don't understand first?*

Ps: *No, not at all.*

N4 (3): *Is there anything that you want to add. - want to ask?*

P: *What about driving?*

N4 (3): *Driving - it's best to sort of like wait a couple, two or three weeks really. To make sure you're feeling like ok. No, I don't see why not. If you feel comfortable driving. If you do it once and you may find that you get achy afterwards like the next day you feel really tired and achy and you'll know it's down to the driving and you know to take it a bit easier. Your body will tell you anyway when you have done too much. It's best not to do that much before it gets that far."*

Although there is some attempt here to elicit individual patients' needs, other interactions contained the same inequality of nurse-patient contribution and standardization of advice which characterized the process of giving preparatory information during the process of admitting a patient (above). A further example by the same nurse was recorded whilst offering discharge advice to a group of several patients who had undergone major gynaecological surgery:

P: *"I'm just worried about my diabetes."*

N4 (3): *"Your diabetes, yeah. That's (referring to an information sheet) just a guideline really as to what are the best foods to eat really for a high fibre diet. You'll find your bowels will settle down in a few weeks and get back to normal again. Don't increase your fibre too much otherwise you'll end up going to the other end, extreme and getting diarrhoea, but it is preferable to eat high fibre foods really for..... to regulate your bowels. So if you just read that through and take it home. Can't think of anything else. If you do get any discomfort do take some Paracetamol when you get home. You can have it four hourly, but you're not to have more than eight in a day, because that's your safe dose in a day, only eight tablets a day, so try and space them out with your meals at breakfast, lunch, tea and supper, and it should be alright. Try not to overeat when you get home as that's normally the cause of people putting weight on, and you do find that a lot of ladies do because they go home and they're not as active as they usually are....."*

The interaction continues in this manner for several more minutes. Whilst it may be difficult to cater for individual patients' needs in a group situation, the patient's concern about her diabetes is clearly not addressed by the nurse, who goes on to give generalized advice from what seems like her own pre-determined agenda.

Thus, the data illustrate once again that although nurses were involved in giving information to their patients, this was not being done in such a way that it could be considered to constitute skilful and effective health education as it is currently understood. That is, it was not based on fundamental health education principles such as collaboration, equity and individualized, two-way communication.

#### Minimal patient participation

Analysis of non-participant observation notes revealed that some instances of patient participation were documented. These involved examples such as decisions about whether the patient would like a strip wash or bath, and a patient being offered the thermometer to insert into her own mouth. Analysis of the tape-recorded interactions also revealed that some attempts to encourage patients to participate in their care were taking place at the nursing bedside handover. The transcripts showed that some nurses appeared to be using the nursing bedside handover as an opportunity to engage patients in a dialogue about their care. On occasions when the researcher accompanied the nurses on the handover, collaboration was also fostered by some nurses' non-verbal cues such as standing near to the patient rather than at the foot of the bed, and talking within the patients' earshot as opposed to talking over them. The following excerpt is indicative of one nurse's attempt to foster the patient's participation in a discussion of how she had been that morning:

N13 (3): *"So X, how are you?"*

P: *It's warm in here, isn't it?*

N13 (3): *It's very very warm, it's been really really hot, hasn't it? We've not been able to wake up all day because it's so warm. How have you been today?*

P: *Not too bad, just a bit of a headache.*

N13 (3): *Headache, I gave you some Paracetamol but that was for a headache rather than for the injections. Do you suffer from headaches a lot? What do you normally take?*



P: *Well, I've been on a course of Samomigrane.*

N13 (3): *Did it help?*

P: *Well it did help."*

However, the approach taken appeared to vary according to the nurse involved, and other examples of interactions were recorded in which collaboration during handover was absent. For instance, in the following example, an enrolled nurse is handing over a patient to the on coming staff:

N8 (3): *"Right, we've had a wash this morning, haven't we?*

P: *Yes.*

N8 (3): *You've done quite well actually, you've sat out, you've made the bed. You're really good for three days. Alright. Had a pack in, and we've taken the pack out, haven't we? Been to the toilet as well. Had a towel bath. What did you think to the towel bath?*

P: *Oh lovely."*

The nurse's use of the term "we" to refer to the patient conveys a patronizing attitude and the way in which she assumes responsibility for communicating what has been accomplished confirms this and is the opposite of a collaborative and empowering approach. Referral to the researcher's observation notes revealed other examples of this particular nurse's approach - for example, talking over a patient to another nurse about social activities whilst bathing a patient which is also likely to have had a disempowering effect on the patient.

Furthermore, the finding that nurses were not collaborating with patients when care planning and updating care plans (see above) represents a further opportunity for participation missed. This therefore substantiates the finding that although some attempts to foster participation were recorded, this was by no means fully integrated into nurses' care on Ward 3.

In addition, comparison of observation and recorded interaction data reveals an interesting point: more examples of information-giving and encouraging patient

participation are found in the recordings of events such as admissions and discharge advice sessions or bedside handovers than they are in the observations of nurses' practice at various non-specific times of the day. This suggests that the practice of these activities may be confined to specific times or associated with particular events such as admissions and the handover period, rather than being fully integrated into all aspects of patient care and contact according to individual patient need. Whilst it is encouraging that some nurses did seem to be utilizing specific incidents as opportunities for information-giving and patient participation, it would seem that full integration requires acting on any opportunity according to patients' expressed needs, regardless of the timing and/or attachment to a particular event. Indeed, the researcher's observation notes document an incident in which a nurse, in response to a patient's expressed need, deferred giving information to a pre-planned time, leaving the researcher feeling that the patient's needs for information remained unmet at that time. Thus, giving information at pre-set times or incidents highlights another way in which the process was nurse-led and standardized as opposed to collaborative and according to individual need.

#### Lack of other health education and health promotion activities

Finally, analysis of data collected from the various methods utilized indicated that other aspects of nurse's potential role in health education and health promotion had not been developed on Ward 3. That is, with respect to health education, no examples were found in the observation notes, recorded interactions or field notes to indicate that nurses were involved in a process of on-going education about diagnoses and management of illness or engaged in dialogue about lifestyle issues in relation to either prevention or with a positive health focus. Further, no dialogue about preventative services available (an aspect of health education referred to in Chapter One and commented on by one nurse in her questionnaire response) was observed or recorded. In the spirit of a new paradigm approach to health education, these activities would be characterized by two-way communication between nurse and patient and would involve a process of fostering life skills, self-esteem and decision-making skills, thus contributing to patient empowerment and an enhanced ability to make informed health choices. These activities would also involve a recognition and attempt to address social and economic constraints to freedom of choice and may also contribute to raising patients' awareness of these as a pre-cursor to individual or collective action to address such barriers. However, no evidence of nurses engaging in these type of activities was found. The data also lacked evidence to suggest that a fundamental re-orientation towards lay participation in the delivery of nursing care had occurred. As indicated above, patients' views and opinions were not sought in the process of giving

information and opportunities for participation in aspects of their care and decision-making had not been taken up by the nurses. And whilst some patients' partners were permitted to stay on the ward - for example if the patient had had a miscarriage - more comprehensive and fundamental examples of relatives' participation in care were lacking from the data collected.

Furthermore, during the period that the researcher spent on the ward, there was no evidence to suggest that the nurses had begun to develop their role at a broader, health promotion level. One staff nurse was reported to be involved in working with a consultant seeing adolescent girls with growth problems in an Out-Patient Department, although her role, and therefore the degree to which this represented an example of health promotion, remained unclear. Otherwise, there was no evidence to suggest that nurses were involved in inter-sectoral work with other professional or lay groups. The nurses' work occurred within the confines of the ward setting and with the patients to whom they had been allocated. There appeared to be no facility for them to become involved in creating and implementing health promoting policy, either within the hospital boundaries or beyond them.

The field notes lend validity and reliability to the conclusions from the observation and recorded interaction data. That is, any activities that could be considered to represent a development of nurses' health education and health promotion role that were recorded represented examples of nurse-led, one-way information-giving primarily, and to a lesser extent, some attempts to encourage patient participation. Towards the end of the data collection period on Ward 3, the researcher's attempts to summarize the health education that had been observed reflects this:

*“ it is mainly explanatory information-giving and some level of participation at bedside handover.”*

### Potential Influences on Practice

Particular influences on practice also emerged – both those that helped to explain the limited traditional-style information-giving that was observed and those that may help explain why more comprehensive development of the nurses' health education and promotion role had not taken place. The type of patients on the ward, or the type of speciality, i.e. the fact that it was a female gynaecology ward, may have helped to explain the existence of information-giving *per se*. This was identified in the field notes and was also cited as a facilitative influence in conversation with two separate members

of the nursing staff on Ward 3. The researcher suggested in the field notes that the patients' apparent receptivity to health advice and information, and willingness to be involved in care may have facilitated the limited development of health education that was observed to have occurred. The age of the patients may also have been a factor prompting the nurses to give information (albeit in a manner which lacked skill and collaboration) or encourage participation in care. As indicated above, the mean age of patients was calculated to be 32 years, based on a random week's admissions. Other research studies are suggestive of a link between age and desire for active participation in health care (for example Strull et al., 1984), leading Brearley (1990) to conclude that preference for information, discussion and participation in decision-making is related to age and socio-economic status. In addition, the nature of the patients' conditions on Ward 3 meant psychological needs and some health education issues were pushed to the fore, for example, support following miscarriage or diagnosis of infertility, and resumption of sexual activity following major gynaecological surgery. These factors may have meant that the health education needs of patients were quite clear to the nurses, prompted by the patients and their diagnoses, and may have been responsible for the limited development of health education that was apparent from observation and recorded nurse-patient interactions.

Conversely, other inter-related influences may have conspired to constrain a more comprehensive development of health education and health promotion. It is evident from the findings about nurses' health education and health promotion practice presented above that the way in which they were developing their role bears some similarities to the ward staff's interpretation of the concepts and of their role ascertained via self-administered questionnaires (see above). That is, both perceptions and practice were characterized by an emphasis on information and advice giving without a recognition of the collaborative nature of this process or of other fundamental principles of health education and health promotion such as lay participation and inter-sectoral collaboration. Therefore, it is likely that limited understanding of what the concepts represent may inhibit the development of practice, both through a lack of vision and consideration of different ways of working and communicating, and through a consequent lack of knowledge and skill with which to translate the appropriate concepts into practice. It is likely that these nurses' lack of awareness of many of the principles and concepts inherent in the recent theoretical models of health education and health promotion are a result of their limited exposure to recent post-registration education on the subject, as indicated by the biographical details of staff who completed a questionnaire (see above).

This was considered to be exacerbated by other factors that helped explain why so little development of nurses' health education and health promotion role had taken place on Ward 3. Analysis of field notes revealed that a possible inhibitory influence was the general approach or philosophy of care which appeared to guide nurses' practice. As the other forms of data collection suggest, nurses seemed to be operating with what was in many respects a task orientation and a medical model type approach to care. This meant, for example, that the shift revolved around the completion of tasks rather than the patient and led to interactions being task rather than patient-centred. The following comment from the researcher's field notes illustrates this:

*"The staff tend to be a bit orientated to getting the work done: I have heard them mention in passing that they have, "already done their observations" or their patient dependency scores."*

This approach is also linked to more traditional ideas of the roles of 'patient' and of 'nurse' and the unequal balance of power inherent in these such that their interactions were characterized by a 'top-down' approach to education and information-giving, which is incompatible with the principles of a new paradigm approach to health education.

Further influences were identified by the researcher which appeared to be associated with this particular orientation to care and which may also have been barriers to the development of health education and health promotion on the ward.

Firstly, the management style of the ward sister was traditional and hierarchical. The researcher's field notes document numerous examples of the way in which her seniority and ultimate responsibility for decision-making was communicated to the other staff – for instance, the ward sister was not a member of either of the recently established nurse teams and continued to do a 'round' of all patients, both at drug rounds and accompanying all nurses on their handover. She was also responsible for decisions such as the allocation of patients and the timing and length of staff breaks. This seemed to have a number of implications. It seemed that nurses' lack of responsibility for, and lack of control over, many aspects of their work may offer an explanation for their apparent control over the patients, resulting in the characteristically 'top-down' approach to information-giving described above as well as an absence of comprehensive and integrated patient and relative participation in care. That is, it is suggested that the hierarchical nature of their working environment had a disempowering effect on the nurses, who, in turn, were unlikely to develop a role for

themselves as empowerers of patients, in keeping with current health education and promotion philosophy. Once again, this supports previous suggestions (Clarke 1991; Tones 1993) that nurses themselves need to feel empowered in order to empower others.

The ward sister's management style also meant that the care and health education advice given sometimes lacked continuity in that such advice came both from the ward sister, whilst on her 'round' of the patients, and from other nurses caring for the patient for that shift. This presumably also had the effect of denying individual nurses total responsibility for patients' care and was also felt by the researcher to have militated against the development of health education and health promotion with patients.

Related to the above, the way in which care was allocated and organized on the ward was also considered to impede the development of nurses' health education practice. Although described as "team nursing", in reality this proved no more than a label, due to the numbers and skill mix of staff which made it impossible to achieve the necessary continuity of care inherent in such systems. The reality of nurses' daily allocation to a geographical part of the ward helped to sustain an essentially medical model approach to care and acted to prevent the implementation of individualized, holistic care of which collaborative and individualized health education could form a part. That is, care was observed to be fragmented and discontinuous and therapeutic nurse-patient relationships were not formed such that the task rather than the individual became the focus of care and individual needs for information and education could not be assessed and worked towards. Coupled with the ward sister's persistence in doing the ward and drug rounds, this system of care allocation was considered to detract from nurses' ability and feelings of responsibility to provide individualized and holistic care, as a basis for a new paradigm approach to health education.

Finally, there was no evidence from the data collected that the nurses had begun to develop their role at a health promotion level by, for example, working collaboratively with other groups on health promotion issues and/or becoming involved in the formation and implementation of health promoting policies. Two factors may help explain this phenomenon. First, the questionnaire data indicated that the ward nurses lacked awareness that this could form a part of their role. Secondly, the researcher felt that the organization of the nurses' work militated against such forms of working. That is, their work patterns were dictated by medically determined admissions and were characterized by a focus on individual patients (or the tasks associated with them), rather than working across boundaries with other professional or lay groups either

within or outside of the hospital. These factors appeared to combine to limit the extent to which nurses were able to engage in health promotion work as it is currently perceived.

To summarize, analysis of the data collected on Ward 3 highlighted the way in which nurses were developing their health education and health promotion role and offered insight into the underlying reasons for this development. This aspect of nurses' role was largely confined to the practice of nurse-dominated information-giving which could be equated to a traditional medical model-derived approach to health education. Whilst some token attempts to encourage patient participation in care were observed, a more fundamental shift to a collaborative approach to care was lacking. Nurses' role in health promotion activities also remained undeveloped. These findings may be explained by the limited way in which nurses interpreted the concepts of health education and health promotion. This was compounded by an essentially medical model philosophy underpinning nursing care at ward level. The consequent table organization and hierarchical management of care may have had a disempowering effect on the nurses and limited opportunities for providing individualized, holistic care and thus health education to patients. In addition, there appeared to be a lack of facility for nurses to engage in activity at a health promotion level.

### **Summary**

Findings from three wards which represent case studies of nurses' health education and health promotion practice in the acute care setting have been described. A comparison of the findings across wards indicates that there were both differences and similarities in the extent to which nurses' had developed their role in health education and promotion. One potentially useful way of expressing these findings is to depict a developmental continuum along which the case study wards can be aligned according to progress made towards the potential role for nurses as outlined in Chapter One. Whilst the difference between health education and health promotion has been acknowledged throughout, it seems useful to conceive of this continuum as representative of *health promoting nursing practice* in order to encapsulate both areas of potential activity. It is recognized that there are potential limitations in adopting this shorthand terminology. However, it is suggested that this term is of use in the context of this study and it will therefore be utilized in describing and discussing the findings in Chapter Six. The differences in practice observed can thus be conceptualized by Ward 2 being further advanced along this continuum than either Wards 1 or 3. Equally, the concept of a continuum accommodates the general finding that the full health promoting

potential had not been realized on any of the wards, including Ward 2. More specifically, differences between the wards were apparent in that on Ward 1 there was an almost complete absence of health education activities and interactions that were consistent with a health promoting approach. On Ward 3 evidence of certain health promoting activities was noted, such as information giving and some minimal attempts to encourage patients to participate in their care. However, these tended to be executed in a nurse- dominated and standardized way, at certain nurse- delineated times of the day, indicating that nurses' practice of these activities more closely approximated a behaviour change, as opposed to self empowerment model of health education. In contrast, on Ward 2 there was evidence that nurses had begun to develop certain aspects of health promoting nursing practice which were consistent with a self empowerment approach and with values associated with health promotion. For example, education was offered in an individualized and collaborative manner and patient participation in activities such as care planning and bedside handover was apparent.

On the other hand, similarities between wards were apparent in that other activities were absent from practice on all three wards. That is, there was a lack of activities such as dialogue about patients' health and lifestyles incorporating a focus on fostering self-esteem and lifeskills as part of an empowerment approach. This is consistent with the finding that nurses on all wards did not appear to have recognized these as part of the concepts of health education and of their role in this. In addition, findings from all three wards were similar in that nurses had not developed their role in health promotion policy activities - that is, those which operate at a broader, structural level.

An overview of the findings from the case study wards also indicates that certain factors can be identified which may influence potential positive progress along this continuum of health promoting practice. The philosophy of care which appeared to underpin practice on Wards 1 and 3 equates with the principles and values inherent in the medical model and this does not appear conducive to the development of practice. In turn, this was associated with task orientation forms of delivering care and a hierarchical style of ward management. It is suggested that the combined effect of these factors militates against enhancing empowerment for nurses and for patients. Nurses on these wards also had limited post-registration education and qualifications. In contrast, on Ward 2 the philosophy guiding practice was one which emphasized such values as individualized holistic care and partnership. As a result, care was organized according to a system of primary nursing and managed with a flattened hierarchy in a democratic way. Together with the fact that the nurses on Ward 2 had higher levels of



educational attainment, it is suggested that this philosophy allows nurses a greater degree of empowerment and autonomy in their work. In turn, this may offer an explanation for their comparatively more advanced progress towards an empowering approach to health education with patients.

In addition, some factors which potentially inhibit progress along this continuum were highlighted on all three wards. These may help explain why the full potential for engagement in health promoting practice was not observed on any of the wards. These inhibiting factors concerned the nurses' limited perceptions of the concepts of health education and health promotion and their role in this, as well as their lack of specific knowledge and skills in health education and promotion. It was also noted that there appeared to be a lack of facilities and structures for engaging in health promotion type activities away from the focus of the individual patient and the bedside. These potential influences on nurses' health education and health promotion practice are examined further in the following Chapter in the context of a developmental continuum of health promoting perceptions and practice.

## **CHAPTER SIX**

### **DISCUSSION**

#### **Introduction**

In this Chapter the findings from this study are examined using the vehicle of a proposed developmental continuum of health promoting nursing practice. The findings are also explored in relation to current theoretical literature and relevant previous research, where this is available. Findings concerning both perceptions and practice are examined with reference to key factors which may be influential in determining the degree of progress possible along a hypothetical continuum of both perceptions and practice. In view of the largely unexplored territory of the focus of this research, it is difficult to adopt or construct appropriate terminology which allows potentially complex findings to be presented and potential explanations for them to be offered. It is recognized that the use of terms such as “continuum”, “health promoting nursing practice”, “philosophy” and “empowerment” are contentious and potentially hazardous in relation to the variety of interpretations which can be ascribed to them. Nevertheless, a case is made for their use here as a means of accurately describing and offering explanations for the findings from this study.

#### **Health Promoting Nursing Practice - Current Perceptions and Practice**

In previous Chapters it has been suggested that both the perceptions and practice of nurses found in this study could be described according to a developmental continuum. This continuum represents a range of health promoting nursing practice and incorporates both health education at the level of the individual encounter and nurses’ engagement in broader, health promotion activities. Findings concerning nurses’ perceptions and their practice are discussed in turn with reference to this continuum and the congruence between nurses’ perceptions and their practice is explored subsequently.

#### **Nurses’ Perceptions and Beliefs**

In terms of perceptions about health education and health promotion, one extreme of a continuum can be represented by an absence of recognition and practice of the concepts of health education and health promotion entirely. Adherence to a behaviour change type approach to health education with little understanding of the meaning of health

promotion, its distinction from health education and the values associated with a new paradigm approach to health education and promotion can be described as representative of a minor increase in understanding. However, perceptions and beliefs which are congruent with this can be interpreted as indicative of overall limited progress towards a comprehensive and sophisticated understanding of meanings. At the opposite extreme, an advanced understanding or level of perception would be demonstrated by a recognition of the characteristics of a self empowerment approach to health education, by an understanding of the structural level at which health promotion is considered to operate and by the values that are associated with health promotion activity.

When viewed in the context of a continuum of perceptions, the findings from this study suggest that nurses have advanced little. Their ideas were located at the less developed extreme, typified by adherence to medically derived, behaviour change ideas and traditional roles and activities for nurses. With the exception of one or two responses, the interview data suggest that there is considerable scope for progression along this continuum towards a more sophisticated understanding, congruent with prevailing ideas in the literature.

These findings substantiate those of Gott and O'Brien (1990) who also found that the perceptions of nurses working in a variety of health care settings were limited to reductionist ideologies with advice on lifestyles construed as the major vehicle for achieving their role. Gott and O'Brien also found that nurses were not cognisant of the social and policy level at which health promotion is believed to operate. Nurses' perceptions in this study are also comparable with those of GPs' surveyed in both Nutbeam's (1984) and Collins' (1984) research. That is, the latter expressed ideas about health promotion which equated with medically oriented and individually focused behaviour change approaches in comparison with other occupational groups.

Nurses' perceptions in this study appeared to be more limited than those nurses in Bradford and Winn's (1992) and McBride's (1993) surveys. Whilst it is impossible to rule out real differences in the perceptions of the samples, it is likely, as highlighted earlier, that both of these authors' more favourable findings were an artefact of the method employed. That is, the use of structured questionnaires with the presentation of preformulated statements with which nurses were asked to agree or disagree is likely to have led to an over-estimation of the extensiveness and complexity of nurses' perceptions of the concepts and their role than the use of less guided instruments as utilized in this study.

The finding that nurses' perceptions were limited and linked to more traditional ideas about teaching and advice giving is likely to have a number of implications for their practice. For example, their ability to communicate effectively with others engaged in health promotion work may be inhibited. Cribb and Dines (1993) point out that if individuals operate with different and conflicting models of health promotion, this is likely to prove an obstacle to effective communication. Indeed, the rationale for both Collins' (1984) and Nutbeam's (1984) studies was a concern with the extent to which different occupational groups shared the same philosophies of health promotion in the interests of communication. It is also likely that nurses' perceptions will influence the practice of health education and health promotion, by, for example, constraining their vision of what it is that they are being asked to engage in and limiting their appreciation of the skills involved in this. If nursing practice is based on perceptions and beliefs which equate health promotion with a behaviour change model of health education, then, as outlined in Chapter One, it is likely to be limited in its effectiveness and may be ethically questionable. However, the relationship between nurses' perceptions and practice of health education and promotion is a multi-faceted one, and this point is returned to below following a discussion of nurses' practice on the case study wards.

In summary, the findings from this study suggest that nurses' perceptions and beliefs about the concepts of health education, health promotion and nurses' role in this are limited and equate with the behaviour change model of health education as outlined in Chapter One. The nurses' perceptions can be conceptualized as rooted at the limited extreme of a developmental continuum depicting increasing degrees of sophisticated and comprehensive understandings. This therefore indicates that there is scope for nurses to make progress towards an advanced understanding of what constitutes health promoting nursing practice.

### Observed Nursing Practice

The findings from the case study wards were presented in Chapter Five and it is suggested that there were both similarities and differences between the wards in terms of progress made along a developmental continuum of health promoting nursing practice. One extreme would be represented by a total absence of engagement in health education and health promotion activities. Observations of nursing practice on Ward 1 would indicate location at this extreme. Nursing practice on Ward 3 equated with the elements of the traditional, behaviour change approach to health education. Practice based on such an approach indicates limited progression along the continuum. That is, it is unlikely to be effective, is ethically questionable and is based on an incomplete

understanding of the determinants of health behaviour (see Chapter One). In contrast, nursing practice on Ward 2 appeared to have progressed further towards a self empowerment approach to health education and can thus be described as further advanced along this continuum of health promoting nursing practice. Nevertheless, whilst practice on Ward 2 may have progressed more than on Wards 1 and 3, the findings indicate that the potential for health promoting nursing practice had by no means been fulfilled on this case study ward. Further exploration of the potential role for nurses as outlined in Chapter One and what could be expected at the advanced extreme of the continuum is given below.

An examination of the theoretical literature indicates that certain features should characterize nurses' health promoting interactions with patients as part of a new paradigm approach. These include for example, a concern with both positive health and well being as well as the prevention of disease and an emphasis on self empowerment through promoting self esteem, self efficacy and the acquisition of relevant lifeskills. Both Downie et al. (1991) and Tones (1987) also suggest that the process of such interactions should reflect a collaborative approach with two way communication or dialogue between professional and client. In a similar vein, both Macleod Clark (1993) and Cribb and Dines (1993) propose that certain features or values characterize health nursing or health promotion activities. These include the need for collaboration, participation and a holistic perspective. Whilst examples of individualized advice and a partnership approach were found on Ward 2, in general nursing practice on the case study wards lacked features believed to embody the new paradigm approach to health education.

As discussed in Chapter One nurses have a real potential role in the broader arena of health promotion. Maglacas (1988), Delaney (1991) and Tones (1993) all suggest that nurses should be involved in the creation of policies and environments that help sustain health and others have commented on the need for nurses to be more politically aware as part of their health promotion role (Coxon 1986; Cowman 1989; Williams 1989). The findings from all three of the case study wards indicate that nurses have not yet begun to develop this aspect of their role and had therefore made only partial progress along a developmental continuum of health promoting nursing practice.

Downie et al.'s (1991) assertion that practice has not uniformly kept pace with theoretical developments in the field is therefore supported and the limited empirical data available on health promotion practice in nursing is also substantiated. The lack of patient participation in care observed (on Wards 1 and 3 particularly), supports recent

empirical work by Macleod Clark et al. (1990) and Kendall (1991) who found that nurses' interactions lacked evidence of participation and collaboration with patients / clients. Reporting on work in progress, Meyer (1993a) also documents a lack of lay participation in care on a medical ward which provides the focus of her empirical study. She states that participation in care was not a part of routine practice and on occasions was actively discouraged or not supported by the system. Examples are given, such as a lack of education with patients and a lack of contact with patients' family/ friends during ward rounds. Similarities with the findings from Wards 1 and 3 in this study are therefore apparent.

Gott and O'Brien's (1990) observation of nurses working in a variety of clinical settings yielded a similar picture, leading them to conclude that ideas about partnership and participation had not yet found their way onto the nursing agenda. However, none of the previous studies involved explicit attention to a comprehensive analysis of the development of nurses' health promoting role in the hospital setting. Thus, an important finding in this study is the lack of other features of a new paradigm approach to health education enacted in practice, such as health oriented advice or the use of certain skills to empower patients, as well as a lack of engagement in health promotion activities.

Whilst the nature of case studies precludes generalization, there is a need to address the potential influences on the limited development of health promoting perceptions and practice found in this study. It is also useful to consider the key influences that may help explain the finding that nurses on Ward 2 had developed their health promoting nursing to a greater degree than those on Wards 1 and 3. Possible reasons for this greater development require further consideration and are explored later in this Chapter.

It is apparent that there are similarities between nurses' perceptions and practice of health promotion found in this study. That is, both were limited and bear resemblance to the behaviour change model of health education as opposed to a new paradigm approach or self empowerment model. In terms of a developmental continuum, both nurses' perceptions and their practice can be located towards the less well advanced extreme of a continuum. This, and other facets of the relationship between nurses' perceptions and their practice of health promotion, are explored below.

## The Congruence Between Nurses' Perceptions and Nursing Practice

The nature of the relationship between nurses' perceptions of the concepts of health education and health promotion and their actual practice of these activities is an area largely unexplored by previous research. The data yielded in this study allow some exploration of this relationship. The findings from the ward sister interviews are not directly comparable with the observation of practice on the case study wards due to the differences in samples. Nevertheless, some direct comparison with the perceptions of the ward sisters from the three case study wards is possible. In addition, the questionnaire data from nurses working on the case study wards provides some means of direct comparison between perceived interpretation of nurses' role and the way that this was observed to be enacted in practice.

The findings indicate that there are different facets to the relationship between nurses' perceptions and their practice. Clearly, similarities between the two were found in that certain characteristics were absent from both perceptions and practice. In terms of a developmental continuum representing both perceptions and practice, the findings indicate that in both senses, only limited progress has been made. For example, the fact that the policy level at which health promotion is believed to operate was not recognized by the overwhelming majority of interviewees may be linked to the fact that there was a lack of nurses' involvement in these types of activities in practice. The finding that some ward sisters appeared to advocate patient participation for reasons of expediency rather than because of a philosophical shift towards more collaborative ways of working was also matched by examples of information-giving on one ward (Ward 1) which appeared to be linked to the need for patient co-operation rather than a desire for collaboration. This congruence may be explained in two ways.

First, it is possible to suggest that nurses' perceptions about health education and health promotion are influenced, or determined by, their current ward-based practice. This was apparent in many responses concerning meanings applied to the concepts. Current practice is particularly likely to determine perceptions in the absence of any educational input about health promotion theory and concepts. Whilst there is a lack of previous research into this relationship, some indirect comparisons with Gott and O'Brien's (1990) findings can be noted here. The perceptions of nurses derived from their interviews were not directly compared with their observed practice, but the authors suggest that nurses' practice may have influenced their perceptions. Thus, they propose that the fact that the nurses were unable to distinguish health education from health promotion and prevention in their interviews was because it would make no

sense to them, in practice, to operate analytical distinctions which do not help them organize their practice. Gott and O'Brien state that due to the nature of their practice, academic distinctions between these concepts are relatively meaningless. This relationship is also apparent from their finding that when asked where they had learned their skills in health promotion, the nurses often replied that they had simply picked these up from clinical and personal experience. Both of these findings are suggestive of the fact that nurses' practice helps structure their perceptions.

A second explanation for the similarities between nurses' perceptions and practice of health education and promotion found in this study may be that nurses' perceptions determine their practice. That is, the direction of influence is the reverse of that specified above - rather, limited visions of what the concepts represent and nurses' role in this explain the limited development of practice observed. Once again, there is a lack of previous research which would help to substantiate or refute this claim. It is, however, only logical to assume that unless nurses have sufficient theoretical knowledge about these concepts and a sufficiently developed vision of what their role might entail, then it is not possible for them to fully develop this role in practice.

It is possible that this relationship between perceptions and practice is of a two-way and dynamic nature and that the above are not competing but complementary explanations. That is, nurses' practice is constrained by limited perceptions of the concepts and these perceptions in turn, in the absence of educational input, are determined by current patterns of activity on the ward. Further research is necessary to examine in more detail the nature of the relationship between nurses' perceptions about health education and health promotion and their practice of these activities. Current educational trends involving substantial theoretical input on health promotion in pre-registration Project 2000 courses, as well as input for registered practitioners registering for the ENB's Higher Award Framework, may provide research opportunities to examine this issue further. It may be possible to explore whether more sophisticated perceptions, as a result of these types of educational input, influence nurses' ward-based practice of these activities. However, in view of other findings to emerge from this study, it is likely that nurses' perceptions are not the only determinant of their practice. For example, questionnaire data from the nurses on two of the case study wards indicated that, when specifically asked about their role in health promotion policy formation, reasonably well developed ideas were advanced and yet these were not observed in practice.



It is also apparent from a comparison of the findings from the two stages of data collection that in some ways, nurses' practice did *not* bear out the beliefs and perceptions of practice held by the ward sisters and ward nurses working on the case study wards. Some of the activities that the ward sisters' stated that nurses' were involved in as part of their health education and promotion role were not observed on any of the case study wards. That is, even though perceptions were limited, some of the reported activities were not observed in practice. This would suggest that practice is considered to be more advanced along the developmental continuum described above than the observed reality of practice found in this study. For example, many of the ward sisters reported that nurses were engaged in giving advice about lifestyle issues to patients, particularly in relation to their dietary and smoking habits. Observation and recording of nurses' practice however, elicited very little evidence of these activities. There were no examples of nurses' engaging patients in advice about lifestyle issues such as smoking cessation or dietary advice which would promote or restore health. Bearing in mind that the case study wards were chosen for their potential to exemplify good practice, this suggests that there is a gap between perceptions and practice. This may be explained in a number of ways.

The limitations of self-report data as an indicator of practice has previously been commented on, and may help to explain this mis-match. It is possible that the ward sisters' and case study ward nurses' perceptions were inaccurate due to their desire for their ward to be viewed in a positive light. That is, they may have wished to give a socially desirable response - one which would please the researcher, and thus responses were exaggerated to accommodate this. Indeed, this is a criticism previously levelled at the validity of previous studies by McBride (1993), Bradford and Winn (1992) and Davis (1992) which have failed to move beyond the use of self report data in attempting to describe nurses' health promotion practice. Whilst this explanation cannot be entirely ruled out, the researcher emphasized the confidentiality of the data and her interest in capturing an accurate rather than idealized description of practice, thus encouraging the interviewee to present an honest account of practice. Related to this, it is possible that although the researcher asked for examples of the reality of practice, this was ignored in favour of idealized views about nurses' potential in this area. It is apparent from the case study ward findings that a number of factors conspired to inhibit progression towards health promoting nursing practice. It is therefore possible that the ward sisters' and ward nurses' idealized views about nurses' role were unable to be translated into practice due to the existence of these inhibitory factors. (These inhibitory factors are explored further below.)

A second explanation for discrepancies between perceptions and the reality of practice may lie in the ward sisters' understanding of the concepts of health education and health promotion and the activities that they entail. The fact that their understanding of what is involved was rather limited and simplistic may have led them to overstate the case. For example, a ward sister may have been referring to simply asking a patient about diet as part of the admission process in citing nurses' involvement in "lifestyle advice about diet". Indeed, McBride's (1993) methodology has been criticized in Chapter Two for failing to make this differentiation between simply asking patients about aspects of their lifestyle and the rather more complex task of actually engaging in a health education interaction. In addition, the nurses did not associate comments about patient education with health education principles such as individualized advice, fostering esteem and the development of lifeskills. This may explain why the examples of which they talked were not observed in practice. That is, the theoretical perspectives guiding the researcher's collection of data on the case study wards differed from the more simplistic interpretations of the concepts offered by the ward sisters. Referring to the example above, simply asking a patient about diet or smoking habits would not have been considered an example of health education practice on the case study wards.

It is likely that this lack of congruence between perceptions and the reality of practice may be explained by a combination of the limitations of self report data and nurses' limited perceptions of the meaning of the concepts.

In summary, an examination of the findings from this study indicates that there is some congruence between nurses' perceptions and their practice of health promotion. That is, both were limited and lacked evidence of a recognition of many of the features of a self empowerment approach to health education as well as reference to, and enactment of, activities at the structural level at which health promotion is considered to operate. With reference to a developmental continuum representing progress toward advanced health promoting practice, the findings concerning both perceptions and practice indicate that limited progression had occurred. However, there was also a discrepancy between nurses' perceptions and their practice of health education and promotion. Notwithstanding the limited nature of the nurses' perceptions, many of the activities referred to by the ward sisters and ward based staff were not observed in practice on the case study wards. A number of explanations have been advanced to explain these findings. Whilst perceptions and practice may influence one another, other key influences emerge from this study which may help to explain the findings further. These are examined below.

## **Factors Influencing Health Promoting Nursing Practice**

The findings from this study indicate that nurses' perceptions and practice demonstrated comparatively little advancement along a hypothetical continuum representing progression from an absence of health promoting nursing practice to the full potential as described in Chapter One . However, findings from the case studies of practice suggested that one ward (Ward 2) could be described as further along this developmental continuum than the others. Key factors can be identified which may explain both the limited progression of perceptions and practice that had occurred and the relative advancement of practice observed on Ward 2. The first of these concerns nurses' knowledge and skills in health education and health promotion. A further key factor concerns the philosophy of care adopted to guide practice. Associated with this is the organization and management of care derived from this philosophy. The extent to which nurses experience autonomy and empowerment as a consequence of philosophy and organization of care would also appear to be influential. As these factors offer a potential explanation for the findings from this study, they are explored further below with reference to the possible reasons why they may determine the location of perceptions and practice on the developmental continuum described above. These factors are also discussed in the context of relevant theoretical and empirical work, where this is available.

### **1) Cognitive and Behavioural Influences**

Findings from both the ward sister interviews and the case study ward data collection indicate that educational exposure to the knowledge and skills or cognitive and behavioural competencies required for the promotion of health is a key issue in relation to nurses' ability to develop their health promoting practice. A number of different findings from this study suggest that nurses currently lack these, thus inhibiting the development of more advanced perceptions and practice along the continuum described above. The need for cognitive input is highlighted by the lack of knowledge that the nurses possessed about the meaning and characteristics of health education and health promotion expressed in the interview phase of data collection. It was also clear from the length of time that had elapsed since their training and their lack of post-registration courses on health promotion, that they were unlikely to have been exposed to relevant knowledge and skills. Indeed, a lack of appropriate knowledge and skills to enact health education and promotion in practice was identified as influential by a large number of the ward sisters themselves (n=70 53%). Findings from the case study wards also suggested that the nurses lacked the knowledge and behavioural

competencies or skills to enable them to enact these concepts in practice. Observation and recording of nurses' interactions showed that these were deficient in skills which characterize a self empowerment model or new paradigm approach to health education. As outlined in Chapter One, according to French (1990) and Tones (1987; 1990; 1991) these include, for example, the need to foster self-esteem and self-efficacy and clarify beliefs and values about health issues. In addition, nurses' lack of knowledge and skills may help explain their lack of engagement in health promotion activities, such as the creation of health enhancing policies, or their engagement in actions congruent with health promotion values. The influence of education is also suggested by the finding outlined previously, that the few examples of more advanced perceptions and practice found, were linked with nurses who possessed higher education qualifications. These findings will be discussed in turn.

The finding that the nurses lacked cognitive and behavioural skills relevant to health promotion appears to be congruent with previous research on the influences on nurses' ability to act as health educators. It has frequently been asserted that nurses lack a number of necessary skills: these range from interpersonal or communication skills (Lask 1987), to skills of assessment (Cowman 1984) and teaching-learning theory and principles (Winslow 1976; Smith 1977; Syred 1981; Wainwright 1982; Parker et al., 1983; Lask 1987) as well as sufficient knowledge of the subject area they are required to teach (Winslow 1976; Smith 1977; Syred 1981; Wilson-Barnett and Osborne 1983; Ruzicki 1987). Empirical data from a number of small scale studies lends support to these assertions. With regard to knowledge of the subject of the health education message, studies by Schuster and Jones (1982), Faulkner and Ward (1983) and Honan et al., (1988) highlighted deficits in their respective nurse samples in relation to barium enema procedure, effects of smoking and clinical knowledge respectively. Other studies (Eardley et al., 1975; Murdaugh 1980; Ward and Faulkner 1983) have revealed that nurses appear to lack knowledge of teaching-learning principles and the ability to implement these in practice. However, all of these studies suffer from a number of limitations. Most represent only small scale surveys and therefore involve small samples. Perhaps more significantly, previous research has tended to focus exclusively on a particular aspect of the nurse's role, such as smoking cessation (Faulkner and Ward 1983) or coronary care teaching (Murdaugh 1980). Additionally, these studies limit their focus to patient teaching and the types of skills and knowledge considered necessary reflect the rather didactic and compliance-focused approach that this activity represents. Only one study (Collins 1984) which adopted a broader definition of health promotion has suggested a relationship between nurses' ability to conceptualize a more

comprehensive vision of what health promotion represents and exposure to relevant knowledge during training (see Chapter One).

In the light of recent theoretical developments in the field of health education and health promotion, this study had a broader focus than the research studies described above. Whilst some of the skills and knowledge identified by previous research may be important, to date there has been a lack of empirical work on the cognitive and behavioural competencies required to implement what is referred to here as health promoting nursing practice. Although the extent to which the findings from this study can be generalized is limited, they do suggest that a number of important areas may need consideration if nurses are to make progress towards more advanced health promoting perceptions and practice.

### Knowledge of Health Promotion

In view of the fact that both the ward sister interview and case study ward questionnaire findings highlighted that these nurses were operating with traditional, medical model-derived ideas of health education and promotion, some educational exposure to more recent conceptual and theoretical developments would seem beneficial as an initial step. That is, nurses need a comprehensive and up to date knowledge of what it is that they are being asked to do. Educational input, based on the prevailing consensus about what the concepts represent and the skills involved, would be one way of achieving this. Nursing's governing bodies have recognized the need for an educational emphasis on health promotion. The creation of a practitioner who is proficient in preventing illness and promoting health is a major thrust of the Project 2000 education curricula as advocated by the UKCC (1986). Similarly, learning outcomes for the recently established ENB Higher Award Framework (1991) have been established for health promotion. One of these states that the practitioner should:

“Understand and apply the principles and practice of health promotion in the practitioner's work setting” (ENB 1991: 14).

However, as has been previously pointed out, within these recommendations there is a lack of explicit definition of what health education and health promotion and nurses' role in this actually entails. Gott and O'Brien (1990) also suggest that there is the potential for ambiguity and contradiction, arguing that the different emphases within different definitions of health promotion raise questions about whether, in constructing interventions, the different actors are equally oriented to the same principles and the

same strategies. This therefore highlights the need to be clear, in any educational curricula, about what the concepts and the role for nurses entails. The lack of clarity from the nursing bodies commented on above only serves to confuse the situation and to leave the development of the role in practice open to individual practitioner's interpretations. As the findings from this study indicate, this may result in limited and ineffective practice. Therefore, a coherent framework of health promotion based on the consensus emerging in the wake of the 1986 WHO Ottawa Charter for Health Promotion is needed as a knowledge base for both education and practice. Knowledge of health education which nurses are exposed to should approximate the self empowerment model described in Chapter One, as this is ethically more acceptable (in contrast to the behaviour change approach) and would appear to have a greater potential for successful outcomes.

### Skills in Health Promoting Nursing Practice

The findings presented in this study suggest that, in addition to knowledge about the meaning of health education and promotion and relevant concepts, in order to enact these, nurses also need to be equipped with certain skills or behavioural competencies. These emanate logically from the above description of what the concepts represent. The ward sisters interviewed were not cognisant of what the skills involved in enacting health education and health promotion might entail. Neither were these skills observed to be enacted by nurses in practice on the case study wards. Their interactions were characterized by an absence of health education (Ward 1), by standardized, nurse-led information (Ward 3) and a lack of health oriented advice incorporating fostering of esteem and lifeskills such as decision making (all Wards).

Operationalization of the concepts inherent in a new paradigm approach to health education or a self empowerment model necessitates that nurses are proficient in a range of interpersonal skills. For example, the need for two-way communication between nurse and patient has been highlighted, and the need to foster self-esteem as one means of empowering the patient. However, the requirement for certain types of communication skills is often implicit and there has generally been a lack of rigorous exploration of the link between health education and the use of certain interpersonal skills. Some useful insights are provided by Macleod Clark, Kendall and Haverty (1987) and Macleod Clark (1988). Utilizing a framework for health education interventions based on the nursing process, they describe the communication skills needed at each stage of this process. For example, they suggest that open questioning skills are needed in the assessment phase in order to establish an individual's belief

systems, work within their frame of reference and as a precursor to mutual planning towards healthier behaviour. Listening and encouraging skills are identified as necessary for an accurate and client-centred assessment (Macleod Clark, Kendall and Haverty 1987). Macleod Clark (1988) points out that although the framework was utilized in relation to smoking cessation interventions, the same principles apply whatever the focus of the intervention. Therefore the implication of this study's findings is that there is a need for nurse education to equip nurses with the interpersonal or communication skills necessary for them to fulfil their role as health educators.

The findings from this study suggest that other skills, acquired through education, may also be necessary. The assertion has been made that nurses themselves must be empowered in order to empower others as part of the health education process (Clarke 1991; Tones 1993) and this association was considered to be important in the light of the findings from the case study wards. Clarke (op. cit.) argues that if giving up a controlling role and being "real" to patients is to be a core feature of the nurse's role as health educator, then her own education for learning about such a role must include learning about "self". She cites the use of communication skills, personal effectiveness, counselling, assertiveness training and self exploration as examples of the means by which nurses, through education, may have the opportunity to begin to develop awareness of "self" and build the self-confidence which goes along with it. Tones (1993) also suggests that the proper development of nurses' health promotion role has obvious implications for training and the nurse curriculum. He maintains that not least is the suggestion that assertiveness training should form an important part of the repertoire of social and education skills which will support the nurse's health promotion function.

To develop an effective health education role, the educational process that nurses are exposed to may also be important in addition to the requirement to cover certain subject areas in order to develop skills such as those outlined above. That is, the process of education and training should also endeavour to contribute to an empowered practitioner. Techniques advocated to achieve this include the use of adult learning techniques (Clarke 1991) and contract learning with students (Mazhindu 1990).

The findings from this study also suggest that nurses lack awareness of the actions and values associated with working at a broader, health *promotion* level and in practice there was an absence of activities such as working in collaboration and co-operation with others to create a health promoting environment or policies which enhance health. Therefore, in addition to education which prepares nurses for therapeutic health

education with individuals, skills which would enable nurses to work at the level of health promotion are also required. Ewles and Simnett (1992) outline some practical skills which would enable nurses to manage health promotion work. These include the importance of nurses learning about co-ordination and teamwork, participating in meetings and effective committee work, learning how to work with the mass media, campaigning and how to challenge health damaging policy. Skills such as these could be incorporated into nurse education curricula to foster nurses' involvement in health promotion type activities in both acute and community settings.

It is recognized however, that the task of equipping nurses with the level and range of skills required to fulfil their role in health education and health promotion may not be achieved through pre-registration education alone. It is likely that a certain basic level of skill acquired through a Project 2000 pre-registration curriculum would need to be built on through post-registration and more advanced level courses. In addition, there are many complex issues involved in the adoption by nurses of a broad, health promotion role in that it inevitably introduces a more political stance. In this sense, education in the skills required is unlikely, *by itself*, to have an appreciable difference on practice. The need for appropriate opportunities within the organization of hospital work to allow different ways of working is recommended and discussed further below. Empowerment of practitioners, and of the profession as a whole, may also be required to facilitate this - a point returned to below.

A final issue in relation to cognitive and behavioural influences on the development of nurses' health promoting practice concerns the association between nurses' comparatively more advanced health education practice on Ward 2 and their higher levels of educational attainment. The questionnaire data from nurses on this ward showed that they had, as a group, appreciably higher levels of educational attainment than the nurses working on both Wards 1 and 3. In addition, the ward sister had obtained amongst the highest educational qualifications of the ward sister interview sample. She was the only respondent to identify the distinction between health education and health promotion in a similar manner to that commonly accepted in the theoretical literature. In addition, it was noted that this ward sister was amongst only a small number of respondents who had obtained a Masters level qualification. Further, her "ward sister" post was actually that of a lecturer-practitioner necessitating both education and clinical commitments. Whilst there was no *direct* evidence to support a causal link between education and the more advanced development of health promoting practice observed on Ward 2, it is suggestive of a relationship between the two. It is probable that any facilitative effect would have been due to exposure generally to



further and/ or higher education rather than that which was specific to health education and promotion. That is, these nurses had not undertaken courses in health education and promotion specifically, and in view of the average length since training, they were no more likely to have been exposed to a Project 2000 type, health oriented curricula than their counterparts on Wards 1 and 3. Indeed, their lack of education about specific health education and promotion concepts and skills was apparent in limited questionnaire responses and was considered influential in the only partial development of health promoting practice that was found to have occurred. The mechanism by which education appeared to encourage more collaborative and individualized health education interactions with patients can only be hypothesized as there is a lack of previous research in this area. It is possible that nurses educated to a higher level are able to offer a better quality of care, of which health education is a part. Related to this, it is also possible that the skills required to facilitate partnership and empowerment demand a high level of cognitive functioning. This potential link between more advanced educational attainment and more progressive health promoting nursing practice, adds further to the suggestion that a realistic expectation is required of the level of health promoting practice that nurses at different educational levels are able to achieve.

Alternatively, it may be that the increased knowledge levels of these nurses contributed to their feelings of empowerment and thus their ability to empower their patients as part of their health promoting role. Keiffer's (1984) suggestion that competence is a characteristic associated with empowerment has some relevance here (this is also discussed further below). The link between the acquisition of professional knowledge and the power that this bestows on the practitioner as a consequence is not a new idea. With reference to medicine, both Friedson (1970) and Illich (1977) comment that knowledge is the key which bestows power. However, traditionally it has been assumed that such power would be used to support an imbalance in the professional - client relationship, with the professional retaining power and control over the client. Perhaps in the context of health education, the power accrued from the acquisition of knowledge may have an inverse effect and leads to greater equality within the interaction due to the empowering effect of knowledge on the practitioner and thus their ability to empower the client or patient. However, such a suggestion can only remain speculative at this stage and further research into the nature of the relationship between educational attainment and the ability to develop health promoting practice would seem beneficial.

To summarize, the findings from this study suggest that cognitive and behavioural influences or appropriate knowledge and skills are a key factor influencing nurses' ability to progress towards advanced health promoting perceptions and practice, which incorporates self empowerment health education and action at a health promotion level. The nurses interviewed and those observed on the case study wards were found to lack the necessary knowledge and skills which would enable them to develop their role in this respect. This may help explain the finding that the full potential for practice was not realized on Ward 2, despite a conducive underlying philosophy. Further research is required to determine the extent to which these findings, particularly those from the case study wards, are applicable to nurses more generally. However, the implications from this study are that nurses should be exposed to a comprehensive and up to date knowledge of what the concepts mean and their role in this, based on a framework which is congruent with the WHO's (1986b) Ottawa Charter for Health Promotion. Following from this, nurses will need to acquire certain skills or behavioural competencies in order to operationalize these concepts in practice. Such skills would include interpersonal skills that would allow the development of a self empowerment approach to health education and a curriculum which fosters the empowerment of nurses through attention to both content and process. Skills which would enable nurses to work at the level of health promotion and in accordance with the values embodied by this concept, such as working collaboratively with other sectors and groups to influence equity and the adoption of healthy policies and supportive environments for health, should also be incorporated into nurse education curricula. Some skills may require more advanced cognitive functioning and what may be achieved within a pre-registration curriculum needs realistic consideration. Attention also needs to be given to what degree of health promoting practice is to be expected by nurses at different educational levels and some areas of knowledge and skills may be best introduced at post-basic and/ or higher education levels. However, the provision of appropriate knowledge and skills needs to be viewed in conjunction with other necessary changes. Kendall (1991) has pointed out in relation to the teaching of interpersonal skills, that these can only be of value where a client-centred framework for care is adopted. This further highlights the importance of an appropriate philosophy of care, and it is clear that nurses' progress towards the potential for health promoting practice may be dependant on both education in the knowledge and skills required for health promotion and an appropriate philosophy of care. The influence of the latter on nurses' health promoting practice is explored further below.

## **2) Philosophical Influences**

In the previous Chapter the philosophy underpinning nursing practice on the case study wards was proposed as a key issue influencing the development of nurses' health promoting practice. An overview of findings across cases highlighted that different philosophies of care appeared to be in operation on the individual wards together with different styles of organizing and managing care which were congruent with these respective philosophies. Together, these had the effect of either inhibiting or facilitating the development of health promoting nursing practice at ward level. On Wards 1 and 3 nursing practice was considered to be derived from a medical model of care and was enacted according to what Beardshaw and Robinson (1990) describe as traditional or task allocation nursing. In contrast, on Ward 2 the nursing philosophy was explicitly identified as one which placed value on such concepts as holistic care, the individuality of patients and partnership. The corollary of this was that care was organized and managed according to a primary nursing system with a flattened ward hierarchy. A link was made between this approach and the closer approximation of nurses' practice on this ward to characteristics of a self empowerment model of health education which can be considered to form part of nurses' health promoting potential.

In addition, findings from the ward sister interviews are indicative that adherence to a certain philosophy of care may be influential in determining nurses' perceptions and reported practice of health education and health promotion. It is likely that the ward sisters' limited perceptions of the concepts and their role is linked to their adherence to a traditional, medical model philosophy of nursing care and a lack of recognition of elements which characterize the more recently proposed New Nursing philosophy (Beardshaw and Robinson 1990; Salvage 1990) (see below). The facilitative influence of a certain philosophy of care was also suggested by a minority (n=29 22%) of the interview sample. These nurses considered that an approach to care embodying values such as holism and partnership was necessary for the development of nurses' health education and promotion practice.

Other than Gott and O'Brien's (1990) related finding that nurses' task orientation constrained their interactions with patients (see Chapter Two), this proposal represents a departure from previous research into the factors influencing nurses' ability to act as health educators. Those previously identified include nurses' lack of knowledge and skill (for example, Schuster and Jones 1982; Honan et al. 1988; Murdaugh 1980; Faulkner and Ward 1983), health education not given sufficient priority due to lack of time (Pohl 1965; Murdaugh 1980), support from others within the clinical environment

(Winslow 1976; Smith 1977; Parker et al. 1983) and a number of facets of nurses' working environment (Honan et al. 1988). Thus, these influences could be said to be on a different scale, or require less of a radical re-orientation of practice than a paradigm shift or change in nursing philosophy. This apparent discrepancy between the findings of the current study and that of preceding work may be explained by a number of limitations of previous work. Firstly, as highlighted in Chapter Two, previous work into health education in nursing has tended to restrict its focus to the more narrowly defined area of patient education. This limited focus is in part in function of the fact that much of the work in this area pre-dates the more recent theoretical literature which has emerged since the mid 1980s. Secondly, empirical work has tended to utilize self-report measures to identify influences on practice without observation of practice in the clinical setting. This not only makes the data subject to the inaccuracies that characterize this method of data collection, but also means that the influences identified by the nurses themselves are dependent on nurses' own interpretations of what the concepts of health education and health promotion represent. This latter point is seldom acknowledged and there is an implicit assumption that there exists a comprehensive understanding of the concepts and activities involved. Together, these points serve to limit the confidence that can be placed in the influences identified from previous research and may help to explain the apparent departure of this study's findings. Alternatively, it could be that the factors identified by previous research *are* influential in determining nurses' ability to act as health educators, but only if the basic philosophy underpinning practice is conducive to the development of this role. Kendall's (1991) point referred to above, in relation to the potential benefit of communication skills in encouraging client participation in health visitor- client encounters, is again pertinent here.

In this study, the philosophy underpinning practice offers an explanation for nurses' limited perceptions and practice of health education and promotion and the differential development of practice observed on the case study wards. It is possible to suggest that the continuum of health promoting practice referred to above is underpinned by a similar continuum representing nurses' position in relation to the preferred philosophy of care adopted. That is, one end of this continuum is depicted by adherence to a medical model philosophy of care, with its associated task allocation and hierarchical ward management style. In turn, this is consistent with either very limited and/ or traditional forms of health education practice by nurses which bear close similarities to elements of the behaviour change model described in Chapter One. More advanced progress along the continuum is consistent with the adoption of a New Nursing philosophy, primary nursing as a system of organizing care and facilitative, democratic

styles of ward management. The findings from this study suggest that the latter is more likely to be conducive to forms of health education practice which equate with the self empowerment approach, as outlined in Chapter One.

In order to examine this finding further, an exploration of the relationship between different philosophies underpinning nursing care and the extent to which they may facilitate or inhibit nurses' development along a continuum of health promoting nursing practice is detailed below.

### The Medical Model and Task Oriented Systems of Organizing Care

With reference to nurses' limited perceptions and the limited practice observed on two of the case study wards, a consideration of the characteristics of the medical model and associated concepts makes clear its incompatibility with the development of health promoting practice by nurses. The behaviour change model of health education, derived from the medical model, has already been contrasted to a new paradigm approach or self empowerment model in Chapter One. In the sociological literature, much has been written about the medical model approach to health and illness in an attempt to explain current patterns of service provision, its limitations and the dominance and power of the medical profession. A number of features are believed to be common to this model. These are summarized by Hart (1991) as: a dominant concern with the *organic* appearances of disease; a tendency to ignore or dismiss the link between physical and mental well-being and the sufferer's own account of what is wrong; an orientation towards *cure* rather than the root causes of illness; a focus on the isolated *individual* as the site of disease and a focus on treatment in the medical environment, which is set apart from the normal living environment of the sufferer.

Hart also goes on to link the Parsonian concept of the sick role to this type of bio-medical imagery. She states that the expectations of the role are passivity, trust and a willingness to wait for medical help. It is up to others to care for and cure the condition and getting better cannot be achieved by individuals of their own volition in accordance with the medical model which depicts disease as something that happens to people and is not something which is within their control. Levin (1981), commenting on the limits of what he calls the professional health model, states that this includes the belief that providers possess the knowledge and technology to *know* what is right and to *do* what is best. On the other hand, Levin suggests, consumers are believed to possess a problem and precious little else.

Traditionally, the nursing profession has aligned itself to this model and nurse education and practice has followed the concepts outlined above. Beardshaw and Robinson (1990) also describe traditional nursing as being oriented around the allocation of tasks and routines as opposed to being patient-centred and they suggest that with this approach the role of the patient is:

“Passive recipient of care delivered by a number of nurses according to ward routine” (Beardshaw and Robinson 1990: 20).

Elements of traditional nursing based on a medical model philosophy of care were clearly visible on Wards 1 and 3 where little development of health education had taken place. For example, the emphasis was on *physical* components of disease and patients were frequently observed to be passive recipients of care. Many of the ideas encapsulated by the medical model were also apparent in the ward sisters' interview responses, such as a focus on physical aspects of health and disease and an emphasis on the individual in isolation from the wider environment.

Reflection on the above characteristics makes clear that such a philosophy of care is in many ways contradictory to the ideology of a new paradigm approach to health education and health promotion. It is also likely that if patients adopt the Parsonian sick role associated with this philosophy of care (either by choice, expectation or force), then dependency and passivity will result and active participation in health education will not be possible. As outlined in Chapter One, commentators such as Downie et al. (1991) suggest that what they refer to as the “modern approach” to health education is based on fundamental notions about the patient or client as an active participant in the health education process, which involves partnership and two-way communication and a concern with mental and social as well as physical components of health. Cribb and Dines (1993) also suggest that health promotion embodies certain values - holism, participation, equity and an ethos of collaboration and co-operation. And, as Tones (1987) makes clear, health education is also concerned with raising awareness of the wider, environmental influences on health and disease.

It is therefore unsurprising that the incompatibility of the medical model with health education has been highlighted in the literature (Van Parijs 1980; Levin 1981). Whilst Gott and O'Brien (1990) intimate that this was a connection found in their empirical study of health education in nursing (by suggesting that practice had been fitted into existing ways of working), to date there has been a lack of research which examines this perceived incompatibility. The findings from this study appear to support the idea

that adherence to a medical model philosophy, is a factor which precludes progression along a developmental continuum towards health promoting nursing practice in accordance with certain principles outlined in the literature.

As has been suggested above, the philosophy adopted to guide practice leads necessarily to certain forms of organizing and managing the delivery of care to patients. That is, a medical model philosophy of care results in traditional or task allocation nursing with a clear nurse management hierarchy. Thus, it is recognized that the distinction between the philosophy of care on the one hand and the organization and management of care on the other is a somewhat artificial one. Nevertheless, they are discussed separately here for the sake of clarity.

Characteristics of the organization of care on Wards 1 and 3 were considered to have militated against the development of health education and health promotion in practice. It was noted that an orientation to tasks resulted in a lack of continuity and responsibility for care which was compounded by a hierarchical style of management from the ward sister. It was suggested that this led to nurses experiencing disempowerment and precluded the development of individualized and collaborative relationships with patients which could serve as a basis for health education. In terms of a developmental continuum of health promoting nursing practice, the organization of work according to tasks and the existence of a ward hierarchy are further factors which may inhibit movement towards the full potential for nurses. An exploration of the literature on care organization and management helps explain this finding and makes clear that some systems are likely to be more compatible with essential features of health promoting practice than others.

Pearson (1988) states that the method of work organization is one of the factors which determines the quality of care a nurse is able to give, and he goes on to define the essential characteristics of a number of different methods. Task assignment is described as the traditional method of organizing work in the 1940s, 1950s and 1960s. Pearson states that this system arose because of the adoption of an administrative rather than a professional authority model and argues that it still exists widely in many hospitals. Pertinent to the focus of this study, he further suggests that task assignment clearly militates against individualizing care and improving the quality of patient care. Pearson distinguishes task assignment from what he calls "day-to-day allocation of care". The latter is described as the method whereby each day at the beginning of the shift a nurse is assigned to care for a group of patients and for that shift the nurse gives total patient care. He comments that whilst it has the potential for more holistic and

individualized care, its major disadvantage is that because assignments may change on a day-to-day basis, continuity is disrupted and the opportunity to develop a close nurse-patient relationship is less likely to occur. Salvage (1990) draws on Melia's (1987) study on the occupational socialization of nurses when discussing the possibilities of achieving a partnership relationship between nurse and patient with task allocation in operation. Melia found that the ward's main business was oriented to "getting the work done", with work presented as sets of routines. This method of organizing work, together with the bureaucratic management system employed by most ward sisters, was found to erode the ideal of patient-centred care and led to task-oriented nursing. Salvage points out that all this suggests that nurses would have to rebel against the system in order to build partnerships with patients.

On Wards 1 and 3 in this study, a combination of day-to-day allocation and some degree of task assignment within this, was practiced (although labelled as team nursing, on Ward 3 this was not possible in practice due to staff numbers and skill mix). The above reflections on the limitations of these methods of organizing care make clear why they were not conducive to the development of health promoting practice. That is, nurses were not able to engage meaningfully in health education with systems of care allocation in operation that do not allow for individualized, patient-centred, partnership relationships with patients. Clearly, this is associated with an incompatible philosophy of care, from which the system of care organization derives.

#### Lack of continuity of care

A further feature of task oriented nursing which was considered to compound nurses' inability to develop relationships with patients on Wards 1 and 3, and thus develop their health education role, was the lack of continuity of care which this system entails. Some further exploration of the importance of continuity of nurse-patient contact in the development of health education practice makes clear the limits imposed by task oriented nursing.

In the context of health education, the issue of continuity of care has been explored with reference to patient teaching. Winslow (1976) suggests that continuity is important in order to avoid leaving it undone because "everyone thought that someone else was going to do it." Similarly, Wilson Barnett (1988) also cites continuity of care as essential within the hospital environment to ensure effective patient teaching. The limited empirical data available also suggests that continuity may be influential in relation to patient teaching. In a small study by Tilley et al. (1987), questionnaire data from 38 nurses working in acute care settings revealed that 55% cited as a barrier a lack



of opportunity to teach before patient allocation was changed. Another small study (Murdaugh 1980), involving a sample of 18 nurses working on a coronary care unit, showed that nurses held similar perceptions about the influence of continuity. Asked about the difficulties of implementing patient teaching six months after educational input on this topic, a lack of continuity - defined as not being assigned to the same patient for long enough periods of time - was the second most frequently mentioned difficulty after a perceived lack of time.

However, whilst there is some research into patient teaching, there is a lack of empirical data on the relationship between continuity and nurses' role in a broader vision of health education as outlined in Chapter One. However, a consideration of some of the necessary pre-requisites for health education as identified in the theoretical literature highlights the potential benefit of continuity of the nurse-patient relationship. For example, Ewles and Simnett (1992) state that helping people make health choices requires a commitment of time and effort on behalf of both the professional and the client in order to understand the factors which influence health choices and in order to take considered decisions and actions. They also point out, along with Downie et al. (1991), that it is important that the professional - client relationship is one built on trust and mutual respect. The necessity of continuity of nurse- patient contact thus becomes clear. A consideration of the characteristics of a new paradigm approach to health education as outlined in Chapter One - such as fostering beliefs about self-efficacy and the acquisition of lifeskills - also indicates that continuity of care is a potentially important precursor for delivering this. That is, these activities require skilled interaction by the nurse and may necessitate repeated or continuous contact with a patient in order for them to be developed.

Whilst most of the previous research confines itself to one aspect of health education - patient education - it appears that the findings from the current study support the importance of continuity of care in enabling nurses to develop other aspects of their health education role. The lack of continuity of care as a result of the system of nurse-patient allocation was particularly striking on Ward 1, on which virtually no development of health education had taken place. The apparent lack of individual responsibility for the care of particular patients may also have been created by the lack of continuity of patient allocation on Ward 1 and this also appeared to militate against nurses' engagement in health education. This could be regarded as a new dimension which relates to the importance of continuous nurse-patient allocation. That is, that continuity is important not only for the establishment of an appropriate relationship and for fostering the development of potentially complex activities such as lifeskills and

self-efficacy, but also to ensure that individual nurses assume a sense of responsibility for a patient's care. This point is also related to the responsibility for care and decision-making afforded to individual nurses by the management style of the ward sister, which is discussed further below.

Thus, degree of continuity of care is a further characteristic associated with particular philosophies and systems of managing care. Some degree of continuity may be afforded by day to day allocation of patients, but it is likely that the best method of ensuring this as a basis for health education with patients is to adopt a system of primary nursing (see below). Whilst caution against generalizability from the case study wards is required, the implication is that nurses should continue to move away from task allocation towards systems of care which allow continuity and value the importance of the nurse- patient relationship, as exemplified by primary nursing. The facilitative influence of the latter is explored further in a subsequent section of this Chapter.

#### Hierarchical ward management

A final point to be made in relation to the limiting effect on health promoting practice of systems of care management in operation on Wards 1 and 3 concerns their association with forms of management by the ward sister that are hierarchical and authoritarian (Pearson 1988; Beardshaw and Robinson 1990; McMahon 1990). Beardshaw and Robinson point out that with task allocation nursing the role of the ward sister is to establish and maintain ward routine, liaise with medical staff and supervise the ward team. These features were clearly in evidence from data collected on Wards 1 and 3. Pearson (1988) suggests that this hierarchical supervision dissipates the authority and autonomy invested in individual nurses, and thus militates against their personal accountability to the patient. McMahon (1990) provides some empirical data to suggest that this is indeed the case by comparing power and collegial relations on wards utilizing primary nursing with those on which hierarchical ward management structures were in operation. He found that on the latter type of ward, power was a major component of the observed communication and the ward sister seemed to control the working patterns of all her nurses. Questionnaire data derived from McMahon's study also revealed differences: nurses on the hierarchical wards perceived their intra-professional communications to be significantly more divisive and less collaborative than those nurses on the primary nursing wards.

The findings from the current study indicate that these features may also have an impact on nurses' ability to develop their role in health education. That is, the nurses on

Wards 1 and 3 were likely to have experienced a lack of autonomy and authority as a result of the philosophy of care and the consequent organization and management of care adopted. It is suggested that this may have contributed to their disempowerment and in turn, this was associated with an apparent desire to maintain control and power over patients within nurse-patient interactions and thus, effective health promoting practice was unable to be developed.

It would therefore seem that if nurses align themselves to a medical model philosophy of care, this leads to task allocation as a method of care delivery and these are both incompatible with progressive health promoting practice. The basic tenets of the medical model are contradictory to those embodied by a new paradigm approach to health education and promotion as outlined in Chapter One. The central features of task orientation prohibit meaningful relationships with patients because there is a lack of focus on the individual patient and a lack of continuity of care. Furthermore, the hierarchy engendered by the medical model and task orientation creates a lack of autonomy and empowerment for nurses. In turn, this was found to be linked to nurses' inability to empower patients and it is proposed that adherence to this philosophy and system of care management ensures that nurses' practice remains rooted at the limited end of a developmental continuum of health promoting practice. It is suggested that in order for practice to move forward nurses need to consider an alternative philosophy of practice which lends itself to different forms of care management and has the potential to empower nurses. The comparatively more advanced practice observed on Ward 2 suggests that the New Nursing philosophy and primary nursing may offer a means of achieving this. The relationship of these factors to nurses' ability to engage in health promoting practice is therefore explored further below.

### The New Nursing Philosophy and Primary Nursing

In contrast to Wards 1 and 3, the nursing philosophy on Ward 2 was associated with engagement in health education by nurses in a manner which resembled more closely some characteristics of the self empowerment model of health education outlined in Chapter One. With reference to the continuum of health promoting practice described above, Ward 2 would be located further towards the more developed extreme and it is suggested that the philosophy of care adopted may be partially responsible for this progression. This philosophy was also compatible with the ideas expressed by a minority of the ward sister interview sample. Characteristics of this philosophy differed from those embodied in a medical model approach and appear to be similar to

what has been described in recent nursing literature as the “New Nursing” (Beardshaw and Robinson 1990; Salvage 1990). An exploration of some of the central tenets of this new philosophy of nursing highlights similarities with a new paradigm approach to health education as described in Chapter One and the values characterizing health promotion action as outlined by Cribb and Dines (1993).

Salvage (1990) traces the origins of the New Nursing in the UK back to the early 1970s and links its inception to developments such as the women’s movement which began to challenge nursing’s subordination to medicine, and nascent consumerism, which provoked a re-evaluation of the client-expert relationship. Key texts (Chapman 1985; Wright 1986; Pearson 1988) identify the practitioner and the clinical base as central to the New Nursing in contrast to previous bureaucratic and task-oriented approaches. Beardshaw and Robinson (1990) suggest that central to the new ideology is the notion of care that is precisely tailored to individual patients’ needs as opposed to task-based methods of organising nursing work. They also state that the new approach is based on a highly skilled nurse practitioner who will have the competence and confidence to give individualized care. Clearly then, this approach has the potential to foster nurses’ autonomy and empower individual nurses providing care. Beardshaw and Robinson contrast New Nursing to past and present systems in which untrained staff give care which is supervised by qualified nurses and competence is based on ability to undertake a variety of tasks and “get by and cope”. The role of the patient in the New Nursing is described by Beardshaw and Robinson as that of an active partner in planning for individual needs with the nurse.

Salvage (op. cit.) also points out that it means transforming relationships with patients - away from the medical model, towards a holistic approach promoting the patient’s active participation in care. Salvage further adds that with this approach the patient is seen as a whole person. The New Nursing is also associated with changes in the division of labour and organization of care on the ward, represented by primary nursing. The latter is discussed further below.

Clearly, the characteristics of this new philosophical approach closely resemble those values embodied by health promotion and those identified as forming constituents of a self empowerment model or new paradigm approach to health education as described in Chapter One. That is, there is an emphasis in both on individuality, holism, the patient’s active participation and the need for skilled interaction with the patient as the focus. This overlap may be no coincidence as both New Nursing and the self empowerment approach to health education are influenced by the humanistic school of

psychology. As highlighted in Chapter One, Beattie (1991) draws attention to the latter's origins in humanistic and social psychology. And Salvage (op. cit.) points out that the roots of the New Nursing ideology draw heavily on theories of psychoanalysis and humanistic psychology, especially that of Carl Rogers. Whilst this new approach to nursing has been widely debated in the literature, it has not been explicitly linked to concepts inherent in paradigms of health education and health promotion. The explanations proposed for the findings from this study help make clear that there are similarities between the two and that progress towards fulfilment of nurses' health promoting role may be dependant on a conducive underlying philosophy.

As discussed above, the philosophy of care adopted leads necessarily to certain forms of organizing and managing the delivery of care. That is, the latter forms a vehicle for operationalizing the philosophy adhered to. In contrast to the task orientation of Wards 1 and 3, the New Nursing philosophy on Ward 2 resulted in the organization of care according to a system of primary nursing. It was suggested that this was also a factor which allowed for the comparatively more advanced practice observed on this ward. That is, this was felt to be conducive by both the researcher and several of the nursing staff in that it allowed continuity of care and offered an opportunity for autonomy and empowerment of the nurses. The potential facilitative influence of primary and team nursing was also cited by a sample of the ward sisters in the interview phase of the study. Approximately one third ( $n=39$  30%) of the interview sample perceived their current practice of primary or team nursing as a facilitative influence - via their ability to provide, for example, continuity and individual responsibility for care. Interestingly, of the three ward sisters who referred to their style of management as facilitative in the interview phase of the study, one was the lecturer/ practitioner who managed Ward 2. Therefore, the link proposed in Chapter Five, between her democratic management and the nurses' ability on Ward 2 to engage in health education with patients is perhaps not surprising and indicates that she had purposefully instituted this on the ward.

There is a lack of previous research which explicitly explores the link between primary nursing and nurses' health promoting practice, although some potential links can be made by an examination of the relevant theoretical and empirical literature, as outlined below.

Beardshaw and Robinson (1990) highlight that primary nursing is a major method for organizing patient-centred care, which they equate with the idea of New Nursing (as discussed above, this equation was clearly seen on Ward 2). They suggest that this involves allocating 24-hour responsibility for each patient's care to a trained primary

nurse who acts, “with the active collaboration of the patient.” They also state that it involves establishing a “detailed and holistic” care plan with the patient. Both Pearson (1988) and Salvage (1990) make similar observations. Salvage (1990) states that the nurse’s role is partly that of teacher or facilitator, enabling patients to marshal their own healing resources and also requires involving patients as partners in care to increase their knowledge and control of their health. Reed (1988) also points out that the philosophy of primary nursing emphasizes a basic, one-to-one nurse-patient relationship and individualized patient care.

Clearly, the theoretical concepts underpinning primary nursing are congruent with both the New Nursing philosophy and some of the principles embodied in a new paradigm approach to health education. For instance, the concepts of partnership and individualization are common to both. Also implicit is that primary nursing aims to ensure good continuity of nurse- patient contact, as it is based on a need to establish therapeutic nurse- patient relationships. This is congruent with the value placed on nurse-patient relationships within the New Nursing philosophy. The importance of continuity of nurse- patient contact for the development of effective health education has been discussed above. Whilst the systems of task orientation in operation on Wards 1 and 3 did not provide this, primary nursing was considered to offer a means of achieving this by both the researcher and several of the nurses on Ward 2. In turn, this appeared to be another way in which primary nursing allowed for greater development of nurses’ health promoting practice on this ward.

Whilst there has been a lack of previous research which examines this relationship, a small study by Reed (1988) provides some evidence to suggest that primary nursing may be facilitative of nurses’ health promoting practice via its association with a particular philosophy of care. Comparing a number of different outcome variables of team and primary nursing, Reed (1988), found that the nurses working on the primary nursing unit all held a similar philosophy, which was towards individualized patient care. Although definitive conclusions are precluded by the small sample size ( $n=7$ ), this study suggests that primary nursing is associated with a philosophy of care which may be conducive to the practice of health education with patients. The current study provides data (from Ward 2) which supports the link between primary nursing and a shared philosophy of care which emphasizes individuality and holism. It also suggests that these are conducive to the development of health promoting nursing practice.

### Flattened hierarchy and nurse autonomy

In addition to its association with a conducive philosophy of care and the continuity of contact provided, primary nursing was considered to enhance nurses' ability to develop health promoting practice via one further related aspect. That is, both the researcher and several of the nursing staff on Ward 2 suggested that the autonomy or empowerment it offers practitioners may facilitate health education which approximates features of the self empowerment model outlined in Chapter One. Once again, an exploration of relevant literature amplifies this point. The ability of primary nursing to achieve its objectives is seen to crucially depend on the autonomy of individual nurse practitioners. Pearson (op. cit.) outlines this relationship, proposing that individualization of care means, in effect, autonomy to the patient, but this cannot happen if the direct care giver who is with the patient is powerless to allow him to carry out the decisions he makes. Pearson concludes therefore that autonomy for the nurse is necessary to allow autonomy for the patient. As a consequence, the management structure associated with primary nursing focuses on the primary nurse, unlike conventional settings where the hierarchy moves power upwards and away from the practitioner (Salvage 1990). Pearson believes that the lack of autonomy inherent in traditional hierarchical structures not only harms the quality of care, but also reduces the patient's power by reducing the autonomy needed for the nurse to develop partnership with the patient. This theoretical relationship between lack of nurse autonomy and the inability to promote autonomy in patients was clearly seen in practice on both Wards 1 and 3 where traditional hierarchical systems of ward management were in operation. In contrast, primary nursing is associated with a flattened ward hierarchy with responsibility for decision-making devolved to individual primary nurses and the ward sister acting as an adviser or co-ordinator as opposed to a supervisor. Again, these features were evident from data collected on case study Ward 2.

The principle of autonomous primary nurses can be linked to the calls in the health education literature (Clarke 1991; Tones 1993) that nurses themselves must first be empowered in order to empower others as part of the new approach to health education. However, to date there has been a lack of empirical evidence which explores the link between this aspect of management of care and the development of nurses' health promoting practice at ward level.

Whilst not directly exploring health education, the findings from MacMahon's (1990) study on primary nursing, referred to above, shed some light on this area and also bear similarities to the findings of this study. His description of the relationships on the hierarchical wards bears close similarity to the findings from the observational data

from Wards 1 and 3 in this study. For example, he states that on one ward, the ward sister seemed to control the working patterns of all her nurses and nurses were allocated to different “ends” of the ward for each shift, and therefore did not necessarily look after the same patients on consecutive shifts. Conversely, on the primary nursing ward the nurse in charge of the shift was observed to inhibit any power gained from that position and to allow the other nurses to work autonomously. Examples of the way in which this was manifested are again similar to the findings from Ward 2 in this study. For instance, McMahon found that enquiries about the patients were re-directed by the co-ordinating nurse to the individual nurse who was looking after that patient. This was also observed to be the case when doctors, other health care professionals and relatives enquired about patients on Ward 2 in this study.

McMahon concludes that on the wards with a hierarchical management structure power seemed to rest in the position at the top of the hierarchy and that person directed the actions of her peers and checked that they were satisfactorily completed. On the primary nursing wards, power was vested in individuals - nurses sought less approval for their actions, rarely asked for guidance and generally acted more autonomously than on the traditionally managed wards. McMahon recommends that further research confirming these findings would be of value, as would an investigation to demonstrate whether these differences positively affect the quality of patient care. The findings derived from the case study wards in this study appear to be congruent with those of McMahon. These findings also suggest that one way in which lateral management may positively influence the quality of care is through its association with more individualized and participatory health promoting interactions with patients. The mechanism by which this management style facilitates the latter may be explained by the mediating influence of nurses’ own empowerment. This is explored more fully in a subsequent section of this Chapter.

Thus, whilst previous research into primary nursing supports some of the findings from the current study, the latter also adds an important new dimension to what is still an area largely untouched by empirical work. That is, it provides evidence (from Ward 2) to suggest that organizing care via a system of primary nursing, with its associated democratic style of leadership, facilitates development along a continuum of health promoting practice according to some of the principles of a self empowerment model or new paradigm approach to health education. It is suggested that this may be explained by the similarity of the ideological concepts underpinning the New Nursing philosophy and primary nursing on the one hand, and a new paradigm approach to health education on the other, through the continuity of care afforded and by the flattened hierarchy and



autonomy for nurses associated with the New Nursing philosophy and primary nursing.

A final point to be made about the influence of New Nursing and primary nursing on nurses' ability to develop their health promoting potential concerns a note of caution about the exclusive focus on the individual which it may engender. The need for nurses to expand their role in health promotion and take on a more political, policy setting role has been highlighted and recommended by a number of authors (e.g. Maglacas 1988; Delaney 1991). Consequently, it has been suggested above that the potential role for nurses includes involvement in creating health promoting policies and environments through, for example, working collaboratively with others. The reductionist focus of the medical model and its incompatibility with the development of this role has been made clear above. However, the New Nursing philosophy and primary nursing also has the potential to obscure the development of this broader role as a consequence of its focus on the individual nurse-patient relationship. To elaborate, it is useful to consider Pearson's (1988) assertion that therapeutic or New Nursing, delivered via a system of primary nursing, has the individual patient as its focus. He further comments that the organization of ward work is influenced by the wider purpose and organization of the hospital institution itself and that this purpose is "caring for the patient". This assumption can be challenged in the light of recent developments which re-focus on prevention and health promotion in the context of the hospital institution. However, the focus on individuals and caring (whether associated with the medical model or New Nursing) may help to explain the finding in this study that there appeared to be a lack of facilities or organizational structures which allowed for the development of collaborative health promoting ways of working with other groups or individuals within or beyond the hospital setting. During the course of data collection it was apparent that many ward sisters were unaware of initiatives and developments on other wards within the hospital or District more generally. The wards on which they worked tended to be isolated from others within the hospital and many commented on their inability to even leave the ward for a break at meal times. Only isolated examples of collaborative working across traditional boundaries emerged from the data: one ward sister described her involvement in a multi-disciplinary working group set up to influence the hospital meals policy and one of the ward sisters on the case study wards reported involvement in a working group on DHA nutrition policy. All this suggests that the hospital as an institution provides little opportunity for the sharing of ideas and working together in the spirit of health promotion. If existing ways of working within hospital settings are derived from philosophies which involve a focus on individuals, then a note of caution is required. Gott and O'Brien (1990) make a similar point in

relation to the widespread use of the nursing process as a vehicle for delivering care. They comment that the emphasis on the individual within nursing has suppressed what is new and radical about the health promotion movement and that:

“in their anxiety to recognize the whole person, nurses are in danger of divorcing their person from his context. The adoption of the Nursing Process as the central vehicle for teaching and practising care planning when introducing Project 2000 changes might well consolidate the dissonances in relation to nurses’ caring versus health promotion roles” (Gott and O’Brien 1990: 67).

It is not argued here that individualized, holistic care derived from a New Nursing philosophy is incompatible with health promotion work *per se*. Rather, it is suggested that if the focus on individuals leads to certain forms of organizing hospital nursing work, this should not obscure the potential contribution that nurses could make to health promotion away from direct care giving at the bedside. Paradoxically, it is suggested later in this Chapter that a philosophical shift to New Nursing and primary nursing may represent a means by which nurses can progress towards their full potential for health promoting practice as it offers a route to nursing empowerment. Nonetheless, in order to work inter-sectorally with other lay or professional groups in pursuit of policies and environments designed to promote health, appropriate opportunities and structures need to be created within the hospital context and an exclusive focus on individuals and caring may militate against this.

To summarize, the findings from this study suggest that the philosophy underpinning nursing practice may be influential in determining the extent to which nurses in acute ward settings are able to fulfil their health promoting potential. The values and activities which characterize the medical model philosophy of care and an associated task allocation system of organizing care appear to be incompatible with the development of this potential. This was most clearly seen in practice on Wards 1 and 3 and adherence to this philosophy may also be instrumental in explaining the limited perceptions of nurses ascertained in the interview phase of this study. In contrast, the New Nursing philosophy and the system of primary nursing which derives from it appear to offer a basis for nurses to advance along a hypothetical continuum of health promoting practice. The facilitative influence of such a philosophy on nurses’ practice was in evidence on Ward 2 in this study and may help explain the finding that nurses’ potential appeared to have been developed to a greater extent on this ward than the other case study wards.

The centrality of empowerment and autonomy of nurses to the New Nursing philosophy and primary nursing has been referred to above. In view of its importance in offering a potential explanation for the findings from this study, a further discussion of its potential influence on practice follows below.

### **3) Empowerment in Nursing**

The findings from the case study wards and the preceding discussion highlight that a further way in which the philosophy of care may influence nurses' progression along a continuum of practice concerns the extent to which the philosophy adopted enables nurses to feel autonomous and empowered. The facilitative influence of an individualized and holistic or New Nursing philosophy of care, combined with primary nursing and a democratic system of management was most clearly seen on Ward 2. It is suggested that nurses on this ward appeared to experience a greater sense of their own empowerment and in turn this may be associated with more advanced health promoting practice. This was in contrast to the findings from Wards 1 and 3 where the effect of the philosophy and management of care was that nurses lacked control in decision-making and autonomy in their practice, thus making it likely that they felt disempowered. In turn, this may have influenced the nature of nurses' interactions with patients and therefore the extent to which their role in health promoting practice had been developed. This apparent lack of empowerment may also help to explain the finding discussed earlier, that, in one sense, there was a lack of congruence between nurses' perceptions and their practice. That is, the philosophy of care and its organization and management, combined with limited educational exposure to relevant concepts and skills (see above), meant that nurses were unable to translate into practice even the limited, traditional health education activities which they reported were part of their role.

As outlined above, Pearson (1988) has postulated a relationship between nurses' autonomy and their ability to allow autonomy for the patient as part of an individualized approach. However, there is a lack of previous empirical data with which to compare the findings from this study on the relationship between nurses' own empowerment and their ability to develop their health promoting practice. In recent years however, much has been written about this issue, and calls have been made for the need to empower nurses. Gibson (1991) suggests that empowerment is difficult to define and is easier understood by its absence: powerlessness, helplessness, hopelessness, subordination, loss of sense of control over one's life and dependency. These descriptors have obvious implications for nurses and the status of the nursing

profession more generally when viewed in a historical context. It is all too easy to link the concepts of powerlessness, subordination and oppression to a workforce comprised largely of women and one which has traditionally been subordinated to the more powerful medical profession. Not surprisingly, then, it has been asserted that nurses are not empowered, either individually (Benson 1991) or as a professional group (Williams 1987; Gott and O'Brien 1990). The disempowered position of nurses has been linked to negative outcomes such as stress and burnout and consequent difficulties in retention and recruitment (Attridge and Callahan 1989; Mason et al. 1991). Conversely, it is increasingly recognized that facilitating empowerment in others requires the empowerer to have undergone a process of personal empowerment. This idea was proposed by Friere (1972) and has been applied in the nursing context by, for example, Clay (1992) who suggests that it is necessary to empower nurses in order for them to empower the people they serve. Others have argued that empowerment is a necessary precursor to enable the development of professional practice by nurses (Dalton 1990; Weinstein 1991; Carlson-Catalano 1992).

In the context of health promotion, a number of authors (Lask 1987; Watts 1990; Clarke 1991; Tones 1993) have also argued that nurses need to be empowered in order to fulfil their role in this. Clarke (1991) for example, states that with regard to the issue of nurses as healthy role models, individualistic victim-blaming is no more relevant to nurses than others. She argues that just as important as observable good health behaviours in nurses is the development of strong self-image and confidence and that the skills needed revolve around internal mechanisms and self-sentiment rather than external health behaviours. Tones (1993) proposes a similar argument, suggesting that any policy designed to achieve a health promoting hospital should take account of the fact that a hospital comprises a community of both patients and staff. Consequently, he argues, its concern should be to empower not only patients but staff too and in doing so nurses could effectively act as role models for empowerment.

In the light of the literature reviewed in Chapter One, which outlines the characteristics and requirements necessary to enact principles of a self empowerment model of health education and health promotion in practice, it seems only logical that nurses themselves need to experience empowerment in order to foster this with the patients with whom they work. The ability to, for example, work collaboratively, enable a participatory, two-way dialogue and facilitate patients' self-esteem and self-efficacy is unlikely to occur if nurses do not experience such opportunities for themselves in the context of their work at ward level and beyond.

All this suggests that, if nurses are not currently empowered, this will create difficulties in their attempts to develop a health education and health promotion role which is based on attempts to empower others. The findings from Wards 1 and 3 in this study appear to bear this hypothesis out. Whilst there is a lack of previous research into this relationship in ward settings, Meyer's (1993b) report on work in progress shares some similarities. An action research approach was used with multi-disciplinary team members working in an acute ward setting in an attempt to foster lay participation in care. Meyer reports that this was very difficult to achieve, one of the reasons being that there was a lack of equal participation amongst team members. She suggests that the idea of status within the team interfered with the ability to work together to initiate change. Meyer therefore questions how lay people might be expected to participate in care when there was no participation amongst professionals. Similarly, in the current study, the ward hierarchy on Wards 1 and 3 appeared to disempower nurses and it is suggested that they therefore lacked the ability or motivation to empower their patients as part of their health promoting role. In contrast, the philosophy and organization of care on Ward 2 offered the nurses the opportunity for autonomy and empowerment and this was associated with more collaborative and potentially empowering interactions with patients.

A consideration of some of the characteristics of empowerment follows below in order to illuminate this finding further.

#### Characteristics of Empowerment and Their Relationship to Health Promoting Nursing Practice

According to Keiffer (1984), empowerment is associated with such concepts as mutual support, support systems, personal efficacy, competence, self-sufficiency and self-esteem. The findings from this study indicated that many of these applied to nurses on Ward 2. These nurses appeared to enjoy support from both their colleagues and the ward sister. This may have been in part a function of the primary nursing system in operation which was conducive to the development of team working skills.

McMahon's (1990) finding that primary nursing fosters collegial as opposed to hierarchical relationships amongst nurses is also pertinent here. There was a sense of social cohesion and the fact that the nurses socialized together outside of working time was noted by the researcher (see Chapter Five). In addition, the ward sister appeared to foster a climate in which the individual members of nursing staff on Ward 2 were valued and supported. This was in contrast to Ward 1 in particular, where it was found that nurses were not supported or valued in their work. The example pertaining

to the nurses who had experienced violence from a patient illustrates this clearly (see Chapter Five). The competence element of empowerment described by Keiffer was also in evidence on Ward 2. That is, the New Nursing philosophy helped to ensure that nurses' competence was valued rather than their ability to complete tasks. The nurses' competence may also have been related to their comparatively high levels of educational attainment, as discussed above.

The idea that personal efficacy, self-sufficiency and self-esteem are associated with empowerment is also postulated by Tones (1991), and has been highlighted in Chapter One. These concepts can also be applied to the case study ward findings. Tones draws on the theoretical literature pertaining to the concept of control in order to explain this relationship. He outlines Lewis' (1986) typology of control, including the idea of processual control which is relevant here. This variety of control concerns the extent to which an individual might be involved in discussions or decisions affecting any given event or situation and is related to beliefs about control (Tones 1991). Beliefs about control are considered valuable and as contributing to self-efficacy and thus empowerment. This notion of processual control can be applied to the findings from Ward 2, where methods of work organization were found to be characterized by the devolved decision-making which is a hallmark of primary nursing. That is, the fact that individual nurses were able to make decisions about patient care and participated in decisions affecting ward functioning afforded them feelings of control, thus contributing to their own sense of empowerment. As reported in Chapter Five, some of the nurses on Ward 2 were aware that the management of the ward afforded them a sense of individual control. Whilst not referring directly to the concept of empowerment, one nurse's comment that:

*"When X (ward sister) started here, and she came with the idea of introducing primary nursing.....um, as a way of giving us more control...in our practice and a way of giving us more power, and I think it's just evolved in that we want to now give our patients more power as well."*

illustrates clearly the facilitative influence that increased control was perceived to have on nurses' interactions with patients.

Once again, the contrast with the findings from Wards 1 and 3 in this respect is striking, in that on these wards individual nurses appeared to lack any sense of control. Instead, consistent with the task orientation of these wards, the ward sister assumed responsibility for decision making.

In his consideration of the relationship between control and empowerment, Tones (1991) also cites Phares (1962). Phares' assertion is that individuals who feel they have control of their situation are likely to exhibit behaviour that will better enable them to cope with potentially threatening situations than individuals who feel that chance or other non-controllable factors determine whether their behaviour will be successful. In essence then, coping behaviour is believed to be related to perceived degree of control. Applying this idea to the nurses on the case study wards, it is possible that a health promoting nurse-patient interaction which requires the nurse to relinquish her role as "expert" and acknowledge the patient's power represents a potentially threatening situation for the nurse. Indeed, Meyer (1993b) reports that the professionals involved in her ward based study did view the general concept of lay participation in care as a threat to their practice, as it required a change in routine and meant taking some risks. If, as Phares argues, the ability to cope with this threatening situation is related to the degree of control possessed, then this may explain why the nurses on Ward 2 were better able to acknowledge the patients' expertise, as was evidenced for example during bedside handovers. That is, it is possible that this was because they experienced a greater degree of control than their counterparts on Wards 1 and 3. Nurses on Wards 1 and 3 were found to lack control over decisions and actions affecting their work on a day to day basis. In the light of Phares' theory, this may then help to explain why they were unable to engage in potentially threatening collaborative interactions with patients or allow the latter to participate in aspects of their care in the spirit of health promoting practice. Thus, the degree of control offered to individual nurses as a function of the philosophy, organization and management of care on the ward may contribute to their empowerment and help explain the differential development of health promoting practice observed on the case study wards.

The contribution that self-esteem may make to empowerment is commented on by Keiffer (op. cit.), and Tones (op. cit.) also suggests that there is an interaction between control and self-esteem. Thus, the greater degree of control enjoyed by the nurses on Ward 2 may also have been influential in enhancing their self-esteem. However, as Tones points out, many other factors influence self-esteem, such as being treated with respect by significant others. Nurses on Ward 2 were observed to be treated with respect by both colleagues and the ward sister and this, together with their educational attainment and autonomy in their work, may have fostered their self-esteem and thus their empowerment. Again, this may help explain why these nurses were found to be better able to enact certain aspects of a self empowerment model of health education than their counterparts on Wards 1 and 3.

It is significant to note that the control and autonomy invested in individual nurses on Ward 2 appeared to be the result of a deliberate policy to encourage empowerment of nurses which was hospital-wide and instituted by the senior nurse management within that hospital. In a recent paper (Fox 1993), the head of nursing services at the hospital, describes the new culture and new roles for nurses which have been achieved. He states that the nursing service in the District Health Authority concerned has produced an environment where creativity and the introduction of new ideas are the norm. He describes the changes which have led to what he believes to be "the successful empowerment of nurses in practice." These concern senior nurse managers agreeing to develop, "a philosophy which enables individual nurses to take personal accountability for their work." He suggests that this was achieved by a reduction in the number of levels of authority which therefore increased the span of control at each level and automatically reduced the level of bureaucracy. Fox also points out that the policy has been that the ward sister is responsible for the standards of practice, determining with the ward team an approach and organization of care within overall policy and philosophies. This clearly illustrates that there has been a deliberate policy from nurse management at all levels to develop a philosophy which involves increased autonomy of individual nurses, thus fostering their empowerment. Although the researcher was not explicitly aware of this at the time of data collection, the findings indicate that there was ample evidence of the results of this policy in practice at ward level. Whilst this management philosophy aimed at empowering nurses had not been specifically designed with the nurse's health promoting role in mind, the findings from this study suggest that it may facilitate this via the mechanisms described above.

In contrast, this was not found to apply to the nurses on Wards 1 and 3. In essence, Gibson's (1991) description of the characteristics that define an absence of empowerment - powerlessness, subordination, paternalism and a loss of a sense of control - are all relevant to the situation that nurses on these wards found themselves working in. This indicates that they were not empowered and it is therefore suggested that they were unable to empower their patients as part of the development of their health promoting practice.

The above discussion makes clear that a further way in which the philosophy of care adopted may influence nurses' health promoting practice is via the degree of empowerment it offers nurses. There is a lack of previous research which has explored this relationship, although the potential importance of empowerment to the development of nurses' health promotion role has recently been highlighted in the literature. An examination of the characteristics and theory underpinning the concept of empowerment



helps illuminate the finding that practice was more advanced on Ward 2. Caution against generalizing from the small sample of wards in this study is required. However, the potential facilitative influence of empowerment on nurses' health promoting practice provides a further reason for advocating a shift towards a New Nursing, and thus a more empowering, philosophy of care.

Nevertheless, it is pertinent to return to the finding that even on Ward 2, where such a philosophy appeared to inform practice, the full potential for health promoting nursing practice had not been realized. The lack of complete development of health promoting nursing practice on all wards has in part been attributed to nurses' lack of knowledge and skills in health education and health promotion (see above). Further influences on the finding common to all wards that nurses had not begun to develop their role in broader health promotion level activities are explored below.

### **Philosophy, Empowerment and Politics - The Keys to Health Promoting Nursing Practice?**

The implication of the above discussion is that a philosophical shift in nursing, together with appropriate knowledge and skills, is needed to facilitate the development of health promoting practice in acute ward settings. That is, a move away from the traditional, medical model perspective which has informed nursing in the past to one which more closely equates with the values inherent in New Nursing. Claims that a philosophical shift in nursing is necessary for nurses to fulfil their potential as promoters of health have been made by Macleod Clark (1993). Using the terminology "sick nursing" and "health nursing", she states that the latter is characterized by maximizing potential for health and independence, building on people's existing knowledge and experience and helping them become more autonomous and empowered. Further, Macleod Clark suggests that:

"relationships and interactions will *not* change unless and until the philosophy of sick nursing is rejected in favour of a health nursing philosophy which values the principles of collaboration and partnership" (Macleod Clark 1993: 259).

The findings from this study suggest that such a shift *is* indeed necessary. Previously, it has been suggested that its influence would be to facilitate the health education or one-to-one element of health promoting nursing practice. Nurses' limited understandings and education, an orientation to reductionist philosophies and the lack of opportunities

created by the organization of work within hospitals has previously been offered as an explanation for the absence of development of the broader, health promotion aspect of health promoting nursing practice. However, it is also suggested here that in order for nurses to embrace this broader role and thus progress along a continuum of practice, it is necessary to return to the importance of a philosophical shift in nursing. That is, it is argued that an appropriate philosophy of care which empowers nurses is not only necessary for the development of effective and therapeutic health education interactions with patients, but may also offer a route to development of their broader, more political role. This assertion warrants some explication and this is provided below.

The need for nurses to take on a more political role in order to promote health has been recognized and advocated by a number of different commentators (Coxon 1986; Maglacas 1988; Williams 1989; Butterfield 1990; Watts 1990; Delaney 1991) and was outlined in Chapter One. Congruent with the findings of this study, it has also been suggested that nurses' focus has traditionally been on the individual without recognition of the social context of behaviour and their responsibilities to facilitate change at this level. For example, Butterfield (*op. cit.*) asserts that nurses pay more attention to individual attitudes and symptoms of poor health rather than its socio-economic causes and that viewing the world from such a perspective does not entertain the possibility of working to alter the system itself or empowering clients to do so. Maglacas, (*op. cit.*) also argues that nurses' health promotion potential is far from being realized and she ascribes this in part to nurses' lack of understanding of, and involvement in, the social, economic and political realm.

Thus, nurses' lack of engagement in health promotion, as opposed to health education, activities has been asserted and is substantiated by the findings from this study. In order to offer explanation for this, and thus consider the implications for nursing practice, it is perhaps pertinent to return to Williams' (1987; 1989) and Gott and O'Brien's (1990) work. Both claim that in order to develop a lead role in health promotion, the nursing profession needs to free itself from subordination and increase its autonomy and self-determination. Williams asserts that the socio-historical situation of nursing, past and present, is one of subordination and limited power based on interactions between social hierarchies of class and gender. This condition, she argues, has consciousness-structuring effects that explain the profession's preoccupation with what she refers to as atomistic health promotion, derived from the medical model. Williams maintains that the structural and ideological conditions that subordinate the nursing profession are the same as those that result in an inequitable distribution of health and which render an atomistic model of health promotion inappropriate and

ineffective. Gott and O'Brien draw a similar conclusion. They suggest that the nursing profession has a near universal subordinate status vis à vis other professions and interests and that its agenda is divided between the demands of its employing organizations and the priorities of its superordinate allied professions. They suggest that nurses are afforded little authority or control within the health care system and that this directly contradicts the ethos and ethics of health promotion which attempts to address inequities and promote meaningful participation in programmes of health.

In essence, the suggestion is that if nurses are to be able to develop a broader and more political role at the level of health promotion, then empowerment of the profession or empowerment at what could be considered a macro level needs to occur.

Referral to Tones' (1991) description of the process of empowerment of groups of individuals highlights a way in which this may be achieved and has some relevance to the findings of this study. As outlined in Chapter One, he suggests that healthy public policy is needed to remedy health damaging inequalities and create an empowered populace; paradoxically, however, the most significant way to change existing policy is through substantial popular pressure. He argues that in order to create such pressure, people need to believe they can influence the course of events and have the skills to do so: that is, they need to be empowered. Essentially, the reasoning here is that one way of effecting change in policies and the social infrastructure is through the empowerment of individuals. Whilst Tones' description refers to empowerment for health promotion changes, these ideas could also be applied to the position of the nursing profession within society. That is, equality and autonomy for the profession at a social or macro level, as advocated by Williams (op. cit.) and Gott and O'Brien (op. cit.), may be achieved through the empowerment of its individual members. Indeed, it could be argued that the difference between empowerment of the profession at the social or macro level and empowerment of individuals at the micro level is more imagined than real, in that the profession represents a collection of individual members. It is possible to suggest that one precursor of this individual empowerment is the shift to a philosophy of care which facilitates this. Thus, if the philosophy of care and the resultant autonomy and control enjoyed by the nurses on Ward 2 were to become a more widespread phenomenon in hospital ward settings, this may eventually culminate in self-determination for the profession via the empowerment it offers individual practitioners. In turn this empowerment or self-determination of the profession may facilitate a more comprehensive development of nurses' health promoting potential by allowing engagement in broader policy and political activities.

Further insights into this relationship are offered by a consideration of Kieffer's (1984) conceptualization of empowerment as a developmental sequence or a process of becoming. He outlines four stages, the first of which is characterized by the participation of the individual as exploratory, unknown and unsure, while authority and power structures are demystified. The deliberate dismantling of the hierarchical/bureaucratic management structure as quoted by Fox (1993) in the hospital in which Ward 2 was situated has previously been commented on and is relevant to this stage of empowerment. The second stage is termed the "era of advancement" and is characterized by a mentoring relationship as well as supportive peer relationships. There are opportunities for collaboration and mutually supportive problem-solving and the individual develops mechanisms for action and accepts responsibility for choices. Keiffer also suggests that at this stage rudimentary political skills are developed. This second stage in the process of empowerment parallels many of the characteristics of the nurses' work situation on Ward 2, although the data indicated that they may not yet have begun to develop political skills in relation to health promotion. Keiffer's third stage highlights how the philosophy of nursing on Ward 2 may contribute to changes in the status and autonomy of the profession as a whole. He describes this as an "era of incorporation", in which activities are focused on confronting and contending with the permanence and painfulness of structural or institutional barriers to self-determination. Thus, in the context of the current discussion, this may involve confronting some of the barriers to developing a health promotion role referred to by Williams (op. cit.) and Gott and O'Brien (op. cit.). Keiffer states that this phase is further characterized by the development of organizational, leadership and survival skills. The fourth stage is the "era of commitment" in which the individual integrates new personal knowledge and skills into the reality of everyday life.

Thus it is possible that the individual nurses' empowerment which is suggested to have begun on Ward 2 has the potential to evolve into a process which leads to changes in the status and autonomy of the nursing profession more generally, as advocated by Williams (1987) and Gott and O'Brien (1990). Combined with appropriate knowledge and skills and changes in the organization of hospital nurses' work, this may then facilitate not only individual health education with patients, but also the development of nurses' broader, health promotion role. In terms of the developmental continuum referred to previously, a philosophical shift to allow empowerment of nurses may enable progress towards their full potential for health promoting nursing practice as outlined in Chapter One. However, at this stage this hypothesis remains speculative.

## **Conclusion of Discussion**

The findings from this study indicate that there has been a limited development of nurses' perceptions and practice of health education and health promotion in acute care settings. It is suggested that one way of conceptualizing these findings is according to a developmental continuum of health promoting nursing practice depicting increasing sophistication and comprehensiveness of health promoting perceptions and nursing practice. The findings from the ward sister interviews suggest that nurses' perceptions remain oriented to a behaviour change model of health education located towards the limited extreme of this continuum. Similarly, observation of nurses' practice on the wards employed as case studies indicated that, in general, only limited progress towards advanced understandings and practice - congruent with the potential and with principles outlined in the literature - has been made. However, the idea of a developmental continuum also allows for the finding that nurses on one of the case study wards appeared to have progressed further towards advanced practice in some respects.

The findings from both the interviews and the case study wards suggest that a number of key factors may be instrumental in determining the extent to which progress along a developmental continuum of health promoting practice can be made. Firstly, as the nurses themselves in this study identified, appropriate knowledge and skills in health promotion are required. The limited perceptions and practice of nurses found in this study are likely to be partly a consequence of their lack of exposure to relevant knowledge and skills. The implication of this finding is that this will need to be redressed if both perceptions and practice are to move forward. The provision of knowledge about health promotion should be underpinned by a guiding framework of health promotion which is congruent with the current consensus in the theoretical literature. Nurses also need to be equipped with certain behavioural competencies or skills, including interpersonal skills and those that may enable them to work at the level of health promotion.

A further key factor influencing nurses' health promoting role concerns the philosophy of care underpinning practice. Nursing practice on Wards 1 and 3 appeared to have progressed little along a continuum of practice, and this was associated with adherence to a medical model philosophy of care and task allocation as a system of organizing care. It is argued that the values embodied by the medical model philosophy are incompatible with those associated with health promoting nursing practice. Traditional or task allocation nursing which derives from this also limits nurses' potential as it

results in a lack of continuity and responsibility for care and is associated with hierarchical styles of management which leave nurses lacking in autonomy and feeling disempowered. In contrast, the New Nursing philosophy and primary nursing appear to offer a means of facilitating progress towards more advanced health promoting practice. This facilitative influence was in evidence on Ward 2, where nurses appeared to have made greater progress towards developing this potential. It is suggested that the values inherent in the New Nursing philosophy are congruent with those recently espoused in the theoretical literature on health education and health promotion and in addition, primary nursing allows continuity of care. Further, this philosophy offers an opportunity for autonomy and empowerment of nurses at ward level. An examination of the characteristics associated with empowerment offers a potential explanation for its facilitative influence on nurses' ability to empower patients as part of their health promoting role.

In the light of the above, it is argued that a philosophical shift in nursing is necessary, away from the medical model and task orientation towards a New Nursing philosophy and primary nursing which has the potential to empower nurses at ward level. Together with knowledge and skills, this may not only facilitate the development of therapeutic, health promoting encounters with patients, but may also, through empowering individual nurses, facilitate self-determination and autonomy for the profession. Combined with opportunities created by the organization of hospital nurses' work, this may then lead to a consequent development of nurses' broader health promotion role, thus allowing them to fulfil their health promoting potential.

## **CONCLUSION**

In conclusion, a number of key issues can be identified which warrant exploration in terms of their implications for nurses' education and practice and the directions which they highlight for future research. These are explored below.

The findings from this study indicate that there has been a limited development of nurses' perceptions and practice of health education and health promotion in acute care settings. The findings from the ward sister interviews suggest that nurses' perceptions remain largely orientated to a behaviour change model of health education, as outlined in Chapter One. The nurses lacked awareness of many of the concepts inherent in what has been described as a new paradigm approach to health education and health promotion. These characteristics are believed to be essential for ethical and effective practice. The majority of nurses remained unaware of the structural level at which health promotion is considered to operate and their ideas were indicative of individualistic, reductionist ideologies in operation. It is suggested that one way of conceptualizing these findings is according to a developmental continuum of health promoting nursing practice depicting increasing sophistication and comprehensiveness of health promoting perceptions and practice. With reference to this continuum, the findings indicate that nurses' perceptions remain located towards the less well developed extreme. It is argued that such limited vision is likely to have a number of implications for practice. It will inevitably constrain nurses' understandings of what it is they are being asked to develop in the name of health education and health promotion. This is particularly likely to be the case in view of the lack of attention by nursing's professional and statutory bodies and other policy makers to the precise activities and skills required by nurses in order to develop this role. Nurses' limited perceptions found in this study are also likely to undermine their ability to communicate with a shared vision with others engaged in health education and promotion.

Similarly, observation of nurses' practice on three wards employed as case studies indicated that, in general, only limited progress towards advanced understandings and practice - congruent with the potential and with principles outlined in the literature - had been made. However, the idea of a developmental continuum also allows for the finding that nurses on one of the case study wards appeared to have progressed further towards their potential in some respects.

The findings from both the interviews and the case study wards suggest that a number of key factors may be instrumental in determining the extent to which progress along a

developmental continuum of health promoting nursing practice can be made. These concern nurses' knowledge and skills, the philosophy of nursing on which practice is based and the consequent organization and management of care, and the extent to which nurses experience empowerment, both at the individual and the macro or professional level.

Caution against generalization is required, particularly in view of the case study approach employed in order to observe nurses' practice, and the fact that this study represents a beginning rather than an end point in the generation of empirical knowledge in this area which can be used to enhance practice. Nevertheless, it is interesting to consider the implications of the study's findings for nurse education and practice.

Against the backdrop of the move towards an emphasis on health promotion and the policy recommendations regarding nurses' key role in this area, the limited perceptions and practice of these activities by nurses in this study necessitates that educational input on the knowledge and skills required to promote health effectively is required. There would appear to be a need to furnish nurses with an up to date understanding of the meaning of health education and health promotion based on the current consensus in the literature. In addition, nurses need to be equipped with the skills necessary to enact these concepts in practice. Current educational developments in nursing provide opportunities for achieving this at both the pre-registration level (Project 2000), and for qualified practitioners, initiatives such as the ENB's (1991) Higher Award Framework may offer avenues for the development of health promotion knowledge and skills. More advanced or complex skills could also be introduced at higher educational levels.

However, the study's findings indicate that education alone may be insufficient to achieve any real advancement in practice and suggest that a number of changes at ward level are also required. These centre on the need for nurses to continue to disassociate themselves from practice derived from a medical model and its related task orientation to care organization. The relevance of New Nursing philosophy and primary nursing to the new paradigm approach to health education has been explored. It would seem that the implementation of the former at ward level as a method of guiding and organizing care would be one way of facilitating individualized and collaborative health education practice in acute care settings. It would also seem essential to institute measures to encourage the empowerment of nurses both within education and clinical practice settings, in view of its potential importance as an explanatory factor in nurses' ability to develop their health promoting practice. Primary nursing and its associated



democratic management of nursing activity appears to offer one way of facilitating this at ward level and therefore its continued development should be encouraged.

The findings from this study indicated that nurses had not yet begun to appreciably develop their role in health promotion, as opposed to health education, activities. In addition to limited perceptions about this aspect of their role, it appeared that there was a lack of facility for nurses to engage in this type of work within the hospital setting. Thus, in addition to the current focus on the individual patient, changes at an organizational level may also be required for nurses to develop their role in health promotion. That is, at the level of the hospital to facilitate for example, inter-sectoral collaboration towards policies and environments which are supportive of health.

Taken together, these changes may enable nurses to fulfil their key role in health education and health promotion as proposed in recent policy recommendations.

The study's findings also have implications for the direction of future research in this area. In the light of the importance of education in the knowledge and skills required to enact health promotion in practice and the educational trends in nurse education referred to above, this would seem to present an avenue for further empirical investigation. That is, evaluative studies to examine the impact of education on the development of nurses' health promotion perceptions and practice would be beneficial.

A further examination of the influence of the key issues identified in this study is also required. In view of the suggestion that ward based and organizational change may be required to facilitate nurses' health promoting nursing practice, an action research approach would seem ideally suited as a method of enquiry.

Finally, it would also seem that there is a need to continue to develop the theoretical and empirical bases of models of health education and promotion which would enable nurses to adopt effective and ethical practice which is of value to the patients with whom they work.

Much has been written about the need for nursing to develop its role in health promotion in response to changing health care needs and trends in society more generally. In order to ensure that the profession moves beyond the level of rhetoric and towards the integration of health promotion into practice, there is a need to ensure clarity and consensus of vision about meaning, and the knowledge, activities and skills required. Nurses need to be adequately prepared for their role in health promotion and

the practice settings in which they work must be facilitative of the need to practice in new and dynamic ways. It is hoped that this study provides a springboard for debate and discussion about the ways in which this might be achieved.

## **Appendix 1**

# **King's College London**

## **UNIVERSITY OF LONDON**

Cornwall House Annex  
Waterloo Road  
London SE1 8TX.

Department of Nursing Studies

Head of Department: Professor Jenifer Wilson-Barnett PhD SRN FRCN

### **OUTLINE OF STUDY FOR WARD SISTERS**

Dear Ward Sister

I am conducting some research funded by the Department of Health into health education and health promotion in nursing and am seeking your co-operation, as ward sister / charge nurse of your ward, in participating in an interview. This research project aims to identify and examine those factors that both facilitate and inhibit health education and health promotion practice in the acute setting and to provide a picture of current practice on acute wards. It is hoped that a major outcome of the study will be the establishment of guidelines for effective health education and health promotion practice on acute wards.

Part of the study involves interviewing ward sisters and charge nurses about their views on health education and health promotion, its practice on their wards and the factors which they believe influence this. This will enable light to be shed on those factors believed to help nurses put health education and promotion into practice and also to describe the difficulties and constraints faced by nursing staff attempting to do this. In view of the recent emphasis on this aspect of the nurse's role, the important body of knowledge created as a result of these interviews will serve as a valuable resource, guiding attempts to integrate health education and promotion into acute sector practice.

Within X District Health Authority, your ward was one of those selected to be included in the study. Relevant senior nurses have been approached and have given their permission and support for the study to take place.

Later stages of data collection will involve some observation and tape-recording of nursing activities on a small number of selected wards. Should your ward be one of those selected, I would of course contact you again to explain what would be involved in this. You would then be in position to decide whether to collaborate with further stages of the project.

It is appreciated that many demands are made on your time and you are under no obligation to participate in this study. However, your help in this important project by agreeing to be interviewed would be very valuable. It is envisaged that this will take approximately one hour of your time. The information you give will be strictly confidential and used only for the purposes of this research study.

I can be contacted by telephone at Kings College on 071-872-3032. In anticipation, thank you for your help,

Sue Latter BSc (Hons) RGN PGDip HV  
Research Associate

## **Appendix 2**

### **WARD SISTER INTERVIEW SCHEDULE**

- 1. District Health Authority:**
- 2. Hospital:**
- 3. Ward:**
- 4. Name:**
- 5. Date of interview:**
- 6. Type of patients on the ward**
- 7. Years as qualified nurse and details of training / further education**

#### **Section one**

- 8. (i) Explore ward sisters' definition and understanding of health education and health promotion and (ii) any perceived distinction between the two.**
- 9. Ask ward sister to describe the health education and health promotion activities that nurses are currently engaged in on the ward.**
- 10. Ask ward sister to identify any factors that inhibit nurses' ability to put health education and health promotion into practice.**
- 11. Ask ward sister to identify any factors that facilitate or would potentially facilitate nurses' ability to put health education and health promotion into practice.**

#### **Section two**

- 12. Ask ward sister to elaborate on any examples occurring on the ward of:**
  - (i) information giving**

**(ii) patient education**

**(iii) advice on lifestyles**

**(iv) patient participation in care**

**(v) relatives' participation in care**

**12. Any other comments**

### **Appendix 3**

#### **QUESTIONNAIRE FOR WARD NURSES**

**CODE NO.:**

**Please complete the following as fully as possible.**

- 1. Grade and position held on the ward:**
- 2. Length of time worked on this ward:**
- 3. Qualifications, including post registration certificated courses:**
- 4. Date of initial nurse qualification:**
- 5. Date questionnaire completed:**
- 6. As a nurse in an acute ward setting, what role do you think that you have in relation to health education and health promotion?**
- 7. Is there anything that influences your health education and health promotion practice?**

**Yes**

**No**

**If yes, please describe any influences below:**

- 8. Do you believe that nurses have a role to play in influencing the hospital policies that affect health?**

**Yes**

**No**

**If yes, please indicate how nurses could or do do this:**

**Any other comments:**

**Thank you for your help.**

## **Appendix 4**

### **OBSERVATION RECORDING SHEET**

Page no.:

Code:

Date:

| Time | Observations | Comments<br>/ Analysis |
|------|--------------|------------------------|
|      |              |                        |



## **Appendix 5**

### **CASE STUDY WARD PROTOCOL**

#### **DOCUMENTATION AND CODING**

1. List of ward staff, each having a different pre-determined number to ensure continuity of coding between non-participant observation and staff questionnaire.
2. In non-participant observation notes identify Nurses by "N" + Code No. Patients by "P"
3. Other staff members to be identified as follows:  
  

|        |                        |
|--------|------------------------|
| OT =   | Occupational Therapist |
| WC =   | Ward Clerk             |
| PHYS = | Physiotherapist        |
| HO =   | House Officer          |
| Reg =  | Registrar              |
| Cons = | Consultant             |
| Dr =   | Doctor                 |
| SW =   | Social Worker          |
5. Use pre-ruled sheets for non-participant observation, with small left hand margin for recording of times and larger right hand margin for descriptive comments inserted either at the time or later, for clarification purposes. Also for critical, analytical comments. Latter to be distinguished from descriptive comments using different colours or symbols.
6. These sheets should also have boxes to record District Health Authority, hospital and ward codes, page number, and the date.
7. Write only in black ink (for photocopying).
8. Begin a new line for each event.

## **SAMPLING CRITERIA FOR NON-PARTICIPANT FOCUSED OBSERVATION**

1. Identify patients for observation - with consideration to those most likely to have potential for health education interactions - through one or more of the following:
  - (i) Listen to handover
  - (ii) Check nursing records/documentation
  - (iii) Speak to nursing staff.
  - (iv) For ease of positioning / observing
2. Consider allocation of staff and their commitments: i.e. only want to observe practice of qualified staff and/or 3rd year student nurses. NOT health care assistants, auxiliaries or agency/bank staff or those with 'extra' commitments e.g. those likely to be leaving the ward or going on escort duty.
3. Select a small number of patients for observation: around 4-6.
4. Patients selected should be in close geographical proximity to each other.
5. Begin by observing a small group of patients and then as appropriate focus in on one patient/one interaction/incident.

## **TIME SAMPLING**

1. Two hour periods to cover whole day from early morning handover to late shift handover.  
i.e. approx 0700 - 2100 = 14 hours
2. Observation times to cover each of the seven days of the week where possible.
4. No minimum or maximum number for each ward - open and flexible as long as each of the time periods (of which there are 7 per day) is covered at least once.
5. Thereafter sampling to be guided by the data and by staff perceptions of time periods most likely to include health education practice.

## **SAMPLING OF TAPE RECORDED INCIDENTS**

1. To include: Handover, office and bedside.  
Admission Procedure  
Discharge Procedure  
Preparation for surgery/investigations  
Specific teaching sessions/assessments/info-giving sessions  
Other events peculiar to the ward eg cardiac support group  
+ other events selected by ward staff.
2. These incidents are to be taped when possible.
3. No specific numbers of incidents to be recorded or observed. Sampling will be guided by nature of the ward and the data itself.

## **COLLECTION OF CONTEXTUAL DETAILS**

### **1. Ward profile to include:**

- (i) Number of beds
- (ii) Number of specialities
- (iii) Type of specialities
- (iv) Number of staff/skill mix/whether up to establishment
- (v) Patient gender
- (vi) Patient's average length of stay (if computed figure available)
- (vii) Ward layout
- (viii) Ward facilities - day rooms/bathrooms/teaching rooms/offices etc
- (ix) Amount of literature/health education material around the ward (describe in detail)
- (x) Number of consultants
- (xi) Other health education resources available (personnel)
- (xii) Collect relevant documentation (information sheets, care plans etc)
- (xiii) Where documentation is kept
- (xiv) Normal system of organization of care

### **2. Patient details (for ward):**

- (i) Random sample a week of patients admitted and discharged and obtain the following:

Date of admission and discharge

Gender

Age

Diagnosis/reason for admission

Area of residence

- (ii) Random daily sample of patients - obtain information from Kardex/front sheets on all in-patients on a specific day and obtain the following:

Gender

Age

Reason for admission

Date of admission

Occupation

Where possible, ethnicity (via observation,name and/or religion).

**3. Patient profile for observation/ tape-recorded incidents:**

Obtain the following:

Name

Gender

Age

Reason for admission (including investigations etc)

Date of admission

Previous recent admissions/whether known to ward staff.

**4. General contextual details for observation/ tape recorded incidents**

Obtain the following:

Number of staff and skill mix

Number of patients

Admissions/discharges for shift

System of allocation to patients / whether adhered to/degree of continuity of care

Number of patients per nurse

Extra ward demands on staff eg escort, acting up, specializing a patient etc.

**5. Staff Profiles**

Data to be obtained from questionnaires and will include:

Position held on the ward

Length of time on the ward

Qualifications, including post-registration certificated courses

Date qualified.

NB When data is not recorded, indicate possible or likely reason for this.

## **Appendix 6**

# **King's College London**

## **UNIVERSITY OF LONDON**

Cornwall House Annex  
Waterloo Road  
London SE1 8TX.

Department of Nursing Studies

Head of Department: Professor Jenifer Wilson-Barnett PhD SRN FRCN

### **OUTLINE OF STUDY FOR WARD NURSES**

I am conducting some research funded by the Department of Health into health education and health promotion in nursing. Some time ago the sister on your ward participated in an interview in connection with this study and following on from this, I would now like to do some further study on this ward. The research aims to find out about the reality of attempting to put health education and health promotion into practice at ward level. It is hoped to identify the difficulties involved in this, as well as the factors which would make it easier for you. With your permission, I will be observing what goes on in the ward and may wish to tape record some of your interactions with patients. Patients will be asked for their consent to participate and their decision respected if they prefer not to take part. I would like to sit in on handover reports, observe nursing care and will also be asking you to complete a questionnaire. It is important that you do not do or say anything different than you would do normally - I am simply interested in what normally happens when you are in contact with patients.

This study has been approved by the Research Ethics Committee. Senior nurses and Sister X have all agreed to take part and it is hoped that you will also agree to participate. However, you are under no obligation to do so. All information will be confidential and will be retained only for the purposes of this research at Kings College. It will not be available to anyone on this ward or at this hospital. You will also be free to withdraw from the study if, for any reason, you wish to do so.

If you have any questions, please do not hesitate to ask when I am on the ward or by telephoning Kings College on 071-872-3032. In anticipation, thank you for your help,

**Sue Latter BSc (Hons) RGN PGDip HV**  
**Research Associate**

## **Appendix 7**

# **King's College London**

## **UNIVERSITY OF LONDON**

Cornwall House Annex  
Waterloo Road  
London SE1 8TX.

Department of Nursing Studies

Head of Department: Professor Jenifer Wilson-Barnett PhD SRN FRCN

### **OUTLINE OF STUDY FOR PATIENTS**

I am conducting some research funded by the Department of Health looking at the ways nurses help to promote health as part of their everyday work on the ward. Part of the study will involve observing and recording some of the nurses whilst they work. The nurses know about the study and they have agreed to take part.

It is possible that I may also want to tape record some of the nurses' conversations with you. If so, you will be given further information about this and your written consent will be asked for before proceeding. You will not be required to do or say anything different than you normally would. I am simply interested in what normally happens when nurses are caring for you.

All information we receive from you will remain confidential and will be used only for the purposes of this study. If you have any questions, please do not hesitate to ask when I am on the ward or by telephoning Kings College on 071-872-3032. In anticipation, thank you for your help,

Sue Latter BSc (Hons) RGN PGDip HV  
Research Associate



## **Appendix 8**

### **PATIENT CONSENT FORM**

I.....(Name) have received written and verbal information about the Kings' College research project and understand what my involvement in the study entails. I understand that all information will be strictly confidential, that I will not be identified and that the information will be used only for the purposes of this study. I will also be able to ask for observation and / or recording to stop at any time without this influencing my rights and the care I receive on this ward.

On this understanding, I agree to take part in the study.

Signed.....

Date.....

## **Appendix 9**

### **EXTRACT FROM TRANSCRIPT OF A MORE SKILFUL APPROACH TO INFORMATION GIVING ON WARD 1:**

N10 (1): "Ok, so, do you understand why you have been brought in this time?"

P: "Yes, yes"

N10 (1): "Can you tell me?"

P: "They said they were going to do an X-ray, pain killer or something, to find out.....one, to find out what's causing it; two, so's they can get to the pain and treat it, type of thing, like an injection."

N10 (1): "Right. Do you understand how they - how they do this?"

P: "No."

N10 (1): "Ok. Do you want me to explain it?"

P: "Please."

N10 (1): "As well as I can. What it's called is a nerve block, OK. And all your nerves - your main nerves - run down your spinal column, OK, and then branch off through your body and go to the different areas, OK. And at different points along your spine is where it affects different parts of your body."

P: "Correct, yes."

N10 (1): "And then they know.....or say that's your spine, OK, say they went in there - that might be where its affecting you, sort of like your tummy region. So they'd go in there, and they put in like a needle and they can.....they can do it two ways, they can leave a catheter in there, just a tiny little tubing...."

P: (Points to his nose) "It ain't going to go through there and get a catheter?"

N10 (1): "No, no."

P: "I hope they don't forget to get the catheter."

N10 (1): "This is all through your spine. on your back, OK? They can sometimes leave the catheter in there so that they can top up the medication that they put in there, which, which kind of like numbs the nerve endings but it doesn't effect how you move - it doesn't stop your mobility by numbing the nerves."

P: "I see what you mean, yes."

N10 (1): "It just takes away the sensation of pain."

P: "Yes."

N10 (1): "Ok. But what they're more likely to do for you is to just....put a ....needle in and inject some of the medication, which is like a local anaesthetic type thing, and take the needle back out, so you won't have anything there at the end of it."

P: "Ok. They don't go through the nose, do they?"

N10 (1): "No, and you'll be made to feel sleepy when you have it done."

P: "That's alright. Mmmm."

N10 (1): "Ok. And you go to like an X- ray room, because it's all done under X- ray screening, so that they know that they're going in the right place."

P: "Mmm, that's correct."

N10 (1): "Ok, and ..um...you'll have some sleepy medicine - you won't be put right to sleep, but you won't remember anything about it."

**P:** "That's lovely."

**N10 (1):** "Ok, so you won't feel anything either."

**P:** "I'd have another heart operation, I'd have another cancer operation, but I just couldn't take another catheter, you know, because you're awake, ain't you, you know, don't you?"

## **Appendix 10**

### **WARD 2 WARD PHILOSOPHY**

**This is a statement of some of our shared beliefs and values that guide our nursing practice.**

**Every patient deserves the unconditional warm regard of the nurses. Every person is a unique individual with social, psychological and physical and spiritual needs who should be allowed to make informed choices which the nurses will respect. If it seems appropriate the nurses will encourage family and friends to be closely involved in the patient's care.**

**To us the most important aspect of nursing is caring. This includes the development of a partnership between the nurse and the patient. The aim of the partnership is to meet the patient's needs but at the same time to foster personal control and growth of independence.**

**Nursing care is provided by a team of nurses each with a unique and valuable contribution to make. We acknowledge the importance of continuity of care and endeavour to provide this for our patients by using a Primary Nursing System. Every patient on admission is assigned to a small team of nurses, one of whom will be the Primary Nurse. This primary nurse will be responsible for planning the care with the patient using a systematic approach. Whenever on duty the Primary Nurse will look after the patient, in his/ her absence the Associate Nurse will continue the care as planned. Any unqualified staff will be supported and supervised by a qualified member of the nursing team.**

**Knowledge enables people to look after themselves and help prevent recurrence or exacerbation of illness. It is therefore an important nursing responsibility to educate patients and their families. Nurses are part of a multi-disciplinary team which works together to the benefit of patients. Success of the team depends on co-operation and good communication.**

**Nursing care is prescribed using up to date nursing knowledge and in the light of experience. It is every nurses' responsibility to continue his/ her education and to share this knowledge with others. Learning opportunities are provided on the ward and staff are encouraged to attend study days when possible.**

## **Appendix 11**

### **EXAMPLES OF MINIMAL ATTEMPTS TO ADDRESS HEALTH AND LIFESTYLE ISSUES ON WARD 2.**

#### **Example 1**

N15 (2): "So you feel quite happy with your diet then?"

P: "Oh yes, I do, I do."

N15 (2): "And you're happy to make the adjustment to semi-skimmed milk?"

P: "Yes, I mean that's....otherwise there's nothing. I mean I like a salad while my husband doesn't. I have a salad, but I don't go without because....so I have a salad and he'll have his cooked, you know, in the summertime. He never was a lover of salad, he likes his hot, you know (laughs).

N15 (2): "Now, who's going to cook when you get home?"

P: "Oh, he'll help me."

N15 (2): "Will he? "

P: "Oh yes, he's very good."

#### **Example 2**

N15 (2): "How much exercise do you get? Do you manage to get out and have a little bit of a walk or.....?"

P: "No, but I mean I'm on the go all day, sort of thing you know, I mean what with the housework and the cooking and the washing."

N15 (2): "You're not going to be on the go at home are you?"

### Example 3

N5 (2): ".....Right, um...I asked the dietician to come and have a chat with you. Has she been yet?"

P: "No, not yet."

N5 (2): "Are you happy with that?"

P: "Yes, I am. Yes, I would."

N5 (2): "All she's going to do is just go over a healthy diet for you to carry on losing the weight."

P: "Yes"

N5 (2): "Alright, I think she will just confirm what you are already doing."

P: "Yes, I expect so."

N5 (2): "So that should give you a bit of confidence to carry on."

P: "Carry on as I'm doing, yes."

N5 (2): "Ok. I think you've got the basics sorted out in your mind anyway, haven't you?"

P: "Yes"

N5 (2): "You know what sort of foods to avoid?"

P: "That's right, yeah."

N5 (2): "Right, well, if she doesn't come this afternoon, I'll make sure she sees you in the morning before you go. Alright?"

P: "Yes"

## Appendix 12

### EXAMPLE OF WRITTEN DISCHARGE ADVICE FROM WARD 3

#### Pelvic Floor Advice

##### Pelvic Floor Exercise

Lie so that your legs do not touch each other.

Keep your tummy and buttock muscles relaxed **ALL THE TIME**.

Tighten the muscles around your back passage as if you were trying to prevent the passage of wind, then pull up the front as well as if you are preventing the passage of urine. Hold and then relax.

Practice slow and fast contractions in equal numbers.

SLOW - tighten muscles, count 4, relax.      4 times.

FAST - tighten muscles, relax.      4 times.

You will get the best results by practising little and often and, over the weeks, gradually increase the number of contractions you do and the length of time you hold them. Aim at being able to hold for 10 seconds. Practice standing, sitting, kneeling and squatting, as well as lying. Give yourself a trigger to remind you to do the exercises, e.g. do them every time you stand at your kitchen sink, every time the adverts come on T.V., or set a cake timer to ring hourly. No one will be able to tell that you are exercising so you can do it any time, any place.

##### Stop Test

When you pass urine try to stop in mid-flow, hold for a second or two, then relax and empty your bladder. Don't worry if you only slow the stream at first, it should gradually improve the more you exercise.

##### Fluids

You should drink 8-10 cups of liquid each day. Don't cut down on fluids because you are having problems. Only go to the toilet when your bladder is full.

Bladder control is influenced by many things e.g. urinary infections, coughing, sneezing, constipation, anxiety, cold weather, being overweight. If necessary, seek medical advice.



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